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TRUTH IN THE NURSE-PATIENT RELATIONSHIP

By

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Abstract

This inquiry examines the phenomena of the development of truth in the nurse-patient relationship. Specifically the study addresses the question "How does a sense of truth arise in the nurse-patient relationship?" The data were gathered from participative observations in the Kelowna Breastfeeding Centre and in private conversations with the nurse/lactation consultants who worked at the Centre and with the volunteer mothers who attended the Centre. The study begins with a clinical story from my early nursing career that initiated this scholarly exploration. This is followed by an analysis of historical representations of breastfeeding and a presentation of some current scientific-biomedical, political, economic, gender, social and embodied breastfeeding discourses in order to provide context and situate the research. The fourth chapter provides a discussion of hermeneutics as a means to mediate upon the meaning of truth in nurse-patient relationships. This chapter also outlines the ethical and methodological decisions made. The first of four findings chapters is an in-depth investigation of Babywise, a widely promoted childrearing guide. Babywise and its author(s) are critiqued from religious, secular and scientific perspectives. Next the nursing stance of Whatever Works in Your House is introduced and elaborated. Together the nurses and mothers created a home like hermeneutic space that allowed them to challenge prevailing discourses. The stance of Whatever Works in Your House and the creation of a hermeneutic space allowed truth in collaboration to emerge. The following chapter introduces "settling" as an outgrowth of truth arising in the nurse-patient relationship. The concepts of embodiment and improvisation are used to illustrate the settling that occurs for mothers and nurses after a sense of truth had arisen. The chapter concludes with some gardening metaphors that illuminate how nurses at the Breastfeeding Centre are gardeners of the spirit. The final chapter is a reflection upon the potential contributions of breastfeeding to our understanding of life. Breastfeeding is identified as an

exemplar of connection, of embodied knowledge and of a creative, ecological and relational experience.

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CHAPTER ONE: INTRODUCTION

Chapter One is both an introduction and an overview of the research journey examining truth in nurse-patient relationships. More specifically this research is an examination of the question "How does a sense of truth arise in the nurse and breastfeeding mother-infant relationship?

The journey begins in Chapter Two with a discussion of how the above question arose in the life of the researcher. The questions that arose for the researcher about nursing science and its relationship to nursing practice are introduced. The desire to search for a truth that is grounded in the day to day and night to night practice of nursing is highlighted.

In Chapter Three the complex discourses inherent in any discussion of breastfeeding are outlined. This discussion begins with an overview of the conflicting messages that inhere in current stances on breastfeeding. The historical representations of breastfeeding that lead to our twenty-first century understandings of the breast and the breastfeeding are presented. Some current scientific-biomedical, political, economic, gender, social and embodied breastfeeding discourses are discussed in order to situate the research. The chapter concludes with a brief discussion of nursing discourses that challenged the researcher to conduct this study.

Chapter Four provides a discussion of hermeneutics as a means to address the meaning of truth in nurse-patient relationships in a way that acknowledges the complexity of life. This chapter provides an overview of hermeneutics and radical hermeneutics and the philosophical thinking that guided the research. The chapter concludes with a discussion of the methodological steps including ethical considerations and means of data collection used during this journey.

Chapter Five is the first of four findings chapters. This chapter is an in-depth investigation of Babywise , a widely promoted childrearing guide. Babywise and its author(s) are critiqued from a number of differing perspectives, including religious, secular and scientific. A discussion of the meaning of children, of parent-child relationships and the discourses of power and control inherent in the Babywise literature conclude the chapter.

Chapter Six introduces the nursing stance of Whatever Works in Your House. This statement encompasses how the nurses involved in this research approached and worked with breastfeeding mothers. The nurses and mothers together created a hermeneutic space at the Breastfeeding Centre that allowed them to challenge prevailing breastfeeding discourses. The stance of Whatever Works in Your House and the creation of a hermeneutic space allowed truth in collaboration to emerge.

Chapter Seven introduces the term "settling" as an outgrowth of truth arising in the nurse and mother-infant relationship. The concepts of embodiment and improvisation are used to illustrate the settling that occurs for the mother and nurse after a sense of truth has arisen. The chapter concludes with some gardening metaphors that illuminate how nurses at the Breastfeeding Centre are gardeners of the spirit.

The final Chapter Eight is a reflection upon the potential contributions of breastfeeding to our understanding of life. Breastfeeding is identified as an exemplar of connection, of embodied knowing and of a creative, ecological and relational experience.

CHAPTER TWO: EMERGENCE OF THE QUESTION

A question to enter in....

> Where to start is the problem, because nothing begins when it begins and nothing's over when it's over, and everything needs a preface, a postscript, a chart of simultaneous events. History is a construct… Any point of entry is possible and all choices are arbitrary. Still there are definitive moments, moments we use as references, because they break our sense of continuity, they change the direction of time. We can look at these events and say that after them things were never the same again. They provide beginnings for us and endings too.
>
> (Atwood, 1993, p. 76) *The robber bride*

How does one decide where to begin a discussion about relationship and truth – phenomena that by virtue of our humanity we have been immersed in since our first beginnings.

My arbitrary starting place, my referential moment, my beginning, and my entering into this research is a story - an experience I had twenty-six years ago as a recently graduated nurse. It's a story that affects me still and that I have frequently revisited often over the years. My approach in each re- visiting has varied – the stance of self-righteous certainty, the approach of doubt and self–questioning, an attitude of resignation and frustration, a growing awareness of forces and discourses beyond hospital walls that shaped our responses. What lingers and remains are simply more questions…

Glen

Early in my nursing career on a medical unit in a large teaching hospital I cared for a man named Glen who had leukemia. He was in his early thirties and had a wife and two young sons. He was a patient on our unit on and off over the course of eighteen months. Eventually his hospitalizations became more frequent and longer in duration.

The nursing staff came to know Glen, his wife, his mother and his sisters very well. During his last hospitalization, despite frequent donations of platelets from his sisters his platelet level dropped dangerously low. As nurses we knew that this meant that someday he could bleed uncontrollably, most likely a massive cerebral hemorrhage that would be untreatable. As nurses we individually approached the hematologist to speak to Glen and his family about the seriousness of his condition and the possibility of a DNR (do not resuscitate) order. The physician rebuked our overtures, not harshly but with puzzlement – How could we give up on this young man?

Envisioning Glen and his family's last moments together without any chance to talk about his possible death we approached our head nurse. The hematologist also dismissed her concerns and he further ordered that the nurses were not to discuss the subject with Glen or his family.

As nurses we carried on resigned to remaining silent but providing Glen with careful attentive care. Our nursing efforts were probably increased to compensate for what we believed we were not giving him – the truth about what likely lay before him. Invisible barriers sprang up everywhere in my relationship with Glen and his family. Constraint hovered in the background. So much was unspoken and so much was unsaid. It became very difficult even to answer his sisters' basic questions about Glen's deteriorating condition as it felt like I was hovering on the edge of a forbidden zone.

Glen had been hospitalized on isolation for 2 months and his condition was steadily deteriorating. I was working an evening shift with another nurse, Bonnie and an LPN. Bonnie was supervising the portion of the unit where Glen's room was located. It was five p. m. when I heard the Code 99, 3DE announcement over the loud speaker. This was a call for the crash team to our unit. Immediately I knew that was Glen. I had a vision of Bonnie wedging the cardiac board under Glen's back and beginning compressions on his pale, frail chest. I could envision his wife horror stricken, pushed to the periphery of the room while they pounded and poked her husband in some futile effort. Within seconds the crash team arrived and disappeared into Glen's room. Time slowed with their appearance. The hands of my watch barely moved as I waited caring for the other patients on the ward. I willed the crash team to "call" the code – to

terminate it and acknowledge the futility of their actions. I felt removed from my body as it moved about assessing and reassuring other patients

An eternity later, the crash team pronounced Glen dead and were cleaning up the detritus of their efforts. Bonnie and his wife are outside his room, their eyes red rimmed and stunned. I approach them and say I'm so sorry, so sorry and with our arms around each other the three of us begin to sob.

From the vantage point of more than two decades later, I see many things in this story – and many questions – What role did the nurses play in maintenance of this hierarchy? What led to the nurses being silenced and the consequent silencing of the patient and his family? How was one view of the situation privileged? I also identify my own acquiescence in the perpetuation of these hegemonic practices. However, this critical account overlooks both the experiential power of the incident and the moral questions it raises.

Apart from the story's persistence in my memory and still lingering intensity, its referential quality lies in the shattering of my sense of continuity of how things should be and how humans should interact. Overall I am left with a sense that an injustice occurred, that there was a denial of our shared humanity and all present had been diminished by the events. It was my first awareness as a nurse – (someone committed to care) that how to do good was illusive and that the doing of good was neither simple, nor obvious , nor unproblematic. It was a disjuncture in my understanding of the world. I abruptly learned that well-meaning persons with kind intentions could harm and inflict injury, could cause and be complicit to acts that could violate others.

I also know that at the time my view of this situation was quite black and white, and that my preferred course of action was clear. My simplistic analysis of the situation at the time was rivaled only by my naiveté. My perspective was that there was a truth to be told and it should be told. By withholding information about Glen's condition and potential prognosis, he was denied both agency – (the process of self-determination in his care) and action - (the opportunity to act in manners congruent with his beliefs, values and goals). I believed that we defaulted on our professional obligation to assist Glen to act in his own best interest and ensure his moral autonomy. Despite my noble ideals at the time I had not considered the complexity, and uniqueness of people's decision-

making in their efforts towards self-determination. My underlying assumption was that if Glen and his family knew the seriousness of his condition and were informed of the nature and likely outcome of a resuscitation attempt they would have chosen a DNR order.

At the time, I believed that a sense of truth was illusive in this interaction solely because the truth was not told. But life is never that simple.

Why Can't This Be Simple?

Five years later I had completed two and a half years of Arctic Outpost nursing and my midwifery certificate. My midwifery practicum had taken me to every hospital maternity unit in Edmonton, a number of public health units, and the Peace River Hospital. I met mothers, midwives, delivery room nurses, postpartum nurses, and public health nurses, La Leche League members, lactation consultants, and childbirth educators in a multitude of maternal-child settings.

I had met wonderful people who were kind, caring individuals who where passionate about breastfeeding. I worked with them and admired their respectful engagement with nursing mothers and their thoughtful practice. They were committed to ensuring every mother and baby they contacted got off to the best breastfeeding start. Because of our shared commitments, I felt a kinship with them.

However when we talked about the difficulties of supporting breastfeeding in settings where institutional structures and policies worked against it, the conversations would ultimately shift to discussing "those" other people. The basic theme was 'If only those other people would do …, or stop doing….., then these poor mothers wouldn't have problems breastfeeding." Who "those" other people were, was dependent on the standpoint of the speaker. The postpartum nurses would speak of the public health nurses. The public health nurses would speak of the La Leche League leaders or the postpartum nurses. The midwives would speak of the delivery room nurses. Everyone (except the childbirth educators) thought if only the childbirth educators would do a better job of teaching, then…..

It was a most perplexing experience. Why couldn't this be simple? I thought we shared the same truth about the worth of breastfeeding and thought we were on the same team in promoting it. I wondered if these people can't cooperate, who can? How could

they be so similar, yet so different? Who was right? Was anyone right? What was the truth that I could tell about these women? That they were dissatisfied with their jobs and displacing their dissatisfaction to outsiders? That they were rigid in their expectations and unsympathetic to other viewpoints? That their exposure to other practitioners and their practice was limited? That they were professionally responsible individuals who were simply 'naming bad practice'? That they were autonomous individuals struggling for personal power? That they were social actors enmeshed in networks of power that benefited from their "horizontal violence"?

All of these explanations seemed to minimize and trivialize the people and the issues at hand. Each explanation excluded much and disclosed little about the struggles of living and working together. What *was* the truth of this situation? Where did truth lie? How could truth be found in the midst of this complexity and diversity? Is truth even necessary or was I searching for a blind ideal?

I was beginning to see truth as something more than factual information being shared and understand truth as complex, messy, evolving, fluid and relational.

Present Thoughts About Truth

These thoughts bring me twenty years later to the present day. The issues of truth are less clear and certainly more complex than I had ever imagined in my youth. I see a world of textuality and difference and know because of this that life is never simple. I also know that despite our human desires, it can never be made simple. Truth in a complex and incommensurate world cannot be simply reduced to "not lying", or factual correspondence with some concrete entity. I seek an approach that will allow truth to be faithful unto all things. That is an approach that will attest to and keep present the myriad difficulties of life and living.

In my work I'm responsible for teaching the upper level Self and Others classes where students focus on the internal and external influences on relationships. I supervise clinical practicum in a course called Nurses Influencing Change and realize how deeply socialized nurses are to focus on the task at hand and the immediate setting, but how enthusiastic they were to examine issues more broadly. Students report profound differences in their approach to the world after taking these courses. When I began teaching these courses I was excited – I believed we were assisting nurses with the skills

to function at the intimate interpersonal level and to change things at a community or societal level. I believed I was helping them to address the multiple truths that would confront them in practice. Today I question - is that possible and how might that be possible?

When I speak with nurses about their current work and workplaces, I become saddened. Most are deeply conflicted about their work and nursing. I wonder what kind of world I'm preparing student nurses for and feel woefully impotent. I wonder - what will sustain nursing students and what can sustain my fellow nurses in these confusing times? More broadly I wonder - what will sustain the world? My questions about truth emanate from this uncertainty and a desire to think more deeply about the issues at hand.

Nursing occurs in the intimate and privileged relationships with patients and their families and their communities. Yet to not acknowledge the power of larger sociopolitical forces on those intimate relationships is myopic. Smith (2002) captures the social political forces and the current tensions in the world today:

> a profound rupture is evolving between a new, deep social awareness of the human world's interconnectedness (and its interconnectedness to the natural world), while hard-line economistic interpretations of life are insisting on a older rationality that relies on exactly the opposite – a split between subject and object, on a conception of radical personal autonomy, and, most disastrously, on a split between politics (now conflated with economics) and history (p. 11).

As global life insecurity, increasing impoverishment of the majority of the world's peoples and global environmental destabilization spreads and deepens (McMurtry, 2002), what truths can sustain us? In this time of general uncertainty where and how is truth to be found? What can the meaning of truth be in this turbulent context? How to search for truth without denying life's difficulties?

As work with breastfeeding mothers has been a consistent thread throughout my nursing life, I have chosen to examine truth as it shows itself in the nurse and breastfeeding dyad relationship. The assumptions of radical hermeneutics guide the research because a radicalized hermeneutics provides "a reading of life which catches life at its game of taking flight and therefore restores factical existence to its original difficulty" (Caputo, 1987, p. 1).

Activating the Question

> The knowledges of nursing itself are to be found in practicing nursing, reflecting on it (and I would argue, reflecting on the mode of reflecting), and coming to understand ways of being which inhere in the relationships between nurse, patient and contexts in which nursing occurs (Lawler, 1997, p. 11).

Like Lawler, I believe that research must have be grounded in practice. I have chosen to narrow the question about truth in nurse-patient relationships to the practice of breastfeeding. Breastfeeding has always been integral to my nursing life. As a public health nurse, an outpost nurse, a midwife and lactation consultant I have worked for over 20 years with breastfeeding mothers and babies.

Breastfeeding is a microcosm of our cultural, social, political, economic, and gender views about the body and health and the roles of mothering women in our culture at this time. Although a "motherhood issue", the potent, conflicted and largely unexamined representations of breastfeeding, are anything but "motherhood" in the sense of motherhood issues being unquestionable and largely agreed upon. As well 'motherhood issues' have been both sentimentalized so they are hardly realistic renderings of actual mothers' experiences and trivialized so they have been deemed not worthy of further consideration. The illumination of these sentimentalized, trivialized and previously unexamined areas can provide fresh insights and richer understandings of truth in nurse-patient relationships.

Thus breastfeeding provides fertile ground to "'activate' the question" (Cameron, personal communication, Feb 28, 2004) of how nurses go about their work day in the midst of an individualistic, consumption driven society, of institutional policies and strictures, of anxious and suffering women, competing disciplines vying for scarce resources, and conflicting and competing messages about her role as a nurse and about breastfeeding as a biological and social good. How does truthfulness show itself when there are so many competing agendas, meanings, perspectives and demands calling the nurse to respond and be attentive to? How do nurses navigate it and negotiate it, and how do they come to understand? What enables the nurse and the mother/baby to negotiate their way to shared meaning? Are they always able to come to understanding? What does it take for the nurse to dwell with the mother and baby and their experience? What keeps the nurse away from the Now (present) in her encounters with mothers?

Importance of Question of Truth in Current Social Milieu

In the beginning of "Being and Time", (Heidegger, 1927/1996) speaks of forgottenness, or oblivion, as a kind of concealment that forgets what has gone before. It is a forgotteness that neglects the 'hiddenness' of things and so remains blind to the obvious and to truth. For Heidegger, in the age of technology (writing in the late 1920s) this forgottenness or oblivion was the greatest danger that threatens humanity and the world, yet forgotteness is also "characteristic of these times in which we hardly know what to think" (Krell, 1993b, p. 366)

In these times when we hardly know what to think, nurses are called not to let the immensity of the challenges that beset the profession sink them into oblivion. We cannot forget that we are situated in a social, political and economic context. Sources from without direct and organize the conditions of work and radically shape nurses working lives.

Globalization and its constituent troupes of free market economics, corporatism, (Saul, 1995), rampant consumerism, and competitive individualism (Kachur & Harrison, 1999) are the dominating influences in the world today. These forces are not contained within national borders; they are transnational in scope and sweeping in their power and momentum. The tenants of the market economy make every facet of society subsumable under a business model. Health care has become less a service to Canadian citizens than a business to be optimized. More and more hospitals are run on business models by accountants and administrators with little input from those who are knowledgeable in the necessities and contingencies of providing good health care.

This is world where both patients and health care providers are regulated in order to maximize efficiencies and profits. In the 1990's, countries restructured health care with an emphasis on cost containment, downsizing and massive changes in care delivery (Armstrong, 1993; Armstrong, Armstrong, Choinere, Mykhalovskiy, & White, 1997; Stevens, 1993). Technology has also brought changing work environments that threaten to direct rather than support nursing care (see Locsin, 2001; Marck, 2000a, 2000b; Sandelowski, 1999a, 1999b). In some cases hospitals have marginalized professional nursing care through "reskilling" of nursing with replacement of nurses with technicians and care assistants (Kitson, 1997). It is a business model that seeks out the cheapest form

of human capital with no regard for the care provided. The global economy deskills people and organizations "by making the environments in which they live and work unrecognizable to them. It thereby renders their stock of local and tacit knowledge less and less serviceable to them" (Gray, 1999, p. 76)

The ethos behind these decisions is self-referential. It requires no justification other than efficiency and alignment with the prevailing view. It is an ethos that nature and people can and must be controlled and a profit made. It is an ethos that McMurtry (1998; 2002) has identified as out of control. He states the corporate structure of the current global economy has lost sight of the ethical values that ground society. Thus there are no regulating mechanisms and the global economies life blind imperatives are presented to the world as life promoting and life serving (McMurtry, 2002). This results in a disturbing inversion "by reversing the flow by which human understanding is normally achieved. Instead of attending to life directly as a prelude to understanding it, the reversal proceeds from predetermined meaning" (Smith, 2003, p. 494).

When knowledge and misrepresentation become blurred, logics become their opposite (Smith, 2003). For example, the reduction in numbers of professional nursing staff is equated with improving health care. Both the recipients and providers of health care are further manipulated to believe that despite concerns about equity of access, threats to the safety and well-being of patients and their families, and annihilation of nurses' individual and professional integrity, acquiescence to the technological and economic 'realities' is in their own best interests and the only 'realistic' option. Individual patients, health professionals, and their situations are dismissed in the name of fiscal responsibility (Armstrong et al., 1997; Barnes, 2000).

In a world where falsehoods are presented as truth, lying becomes a cultural norm and where in the absence of any notion of the public or the social good, personal truths take precedence, how does one begin the search for truth?

Searching for Truth

> You may remember the story of how the devil and a friend of his were walking down the street, when they saw ahead of them a man stoop down and pick up something from the ground, look at it, and put it away in his pocket. The friend said to the devil, "What did that man pick up?" "He picked up a piece of

> Truth," said the devil. "That is a very bad business for you, then," said his friend. "Oh, not at all," the devil replied, "I am going to help him organize it."
>
> (Krishnamurti, 1929)

Krishnamurti told this story at the beginning of his startling 1929 speech Truth is a Pathless Land where he dissolved the Order of the Star in the East and renounced himself as leader.[1] Although he was cautioning people to the hazards of rigidly following concepts, rules, leaders and organizations in religious life, I have included it here to preface my discussion of my own truth seeking. I believe that the devil's unexpected response catches us off guard and calls us to reflect on our assumptions about truth. The etymological roots of the devil's term *organize* refers to a means of function. The word may also have its roots in the Indo-European word *worg* – to work. Perhaps the moral of this story is that it is not truth that is problematic. Rather it is humans' attempts to make truth work or function for them that truth becomes troublesome. That is, we get into trouble with truth when we attempt to organize it, formalize and regulate it, rather than to live it. Truth cannot be fixed and made rigid to serve our desired functions.

I include the above quote because it reminds me that my research is not about finding a truth, delineating it, and presenting it succinctly. The truth that I am seeking will not be found by distancing myself and taking an objective stance. Therefore my goal is not "to organize the truth". My goal is to let truths emerge that may enter into the ongoing dialogue with truth in life as it is lived. As Wittgenstein (as cited in Jardine, 1998d) noted, while we *can* draw a boundary around something, we cannot however *give* it a boundary that would cut it off and remove it from its integration in our lives and the life of the world around us. I do not wish to draw a boundary around my investigation in ways that circumscribe the limits of what truth can be and can show.

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[1] Krishnamurti was born in south India, the eighth child in a middle-class family in 1895. At an early age he was adopted by Annie Besant, then the President of the Theosophical Society and was educated in England. While a teenager, the Theosophists proclaimed him to be the world teacher whose coming they had been awaiting. They built a large, rich order round him, with many thousands of followers, but in 1929 Krishnamurti disbanded the organization, returned the estates and monies that had been given to him and declared that his only purpose was to set human beings unconditionally free. (Krishnamurti-Foundation, 2004)

The truth that I am interested in is a truth that is grounded in the day to day and night to night practice of nursing. My focus is the existential and phenomenal realm of truth that is found in the particular and the concrete of daily living. In practice settings nurses confront not only their personal and disciplinary concepts of truth, they are also in constant interplay with other disciplines, other cultures, and other individuals' perspectives and at the same time pressured by the prevailing economic interpretations of life. I seek to examine a truth in nursing that acknowledges these interconnections, yet does not acquiesce to the current value structure. A truth that does not seek to divide subject from object, deify economic constructions of life, does not deny history or strive for univocity. I wish to engage in a form of truth seeking that searches for connections, meaning, and strives for multivocity.

Smith (2002) speaking of what allows teaching to live on, states that "teaching cannot be a living if there is not truth told in its enactment or, more accurately, if the classroom is not first and foremost a place of truth seeking, truth discovering and truth sharing" (p. 31). The truth he describes is not an absolute truth but a truth discovered together in collaboration. It is communal and dialogical truths that arise in the moments of living that encourage us and allow us to live on. He elaborates: "a truth for Now, something that provides sustenance for Now precisely because of how coming into truth has it own energizing power (p. 31).

Van Manen has stated the nursing is what makes life livable for patients (M. Van Manen, personal communication, February, 2000). If nursing makes life livable for patients, what makes life livable for nurses and allows nurses and the discipline to go on? What truths can sustain nursing in the Now? How does a sense of truth arise for nurses and patients? How best to 'trouble', that is to reflect upon and question the current reflections of practice and the limitations put on nursing by the economic model of health care and the economic vision of the world? How to explore these questions?

I will begin exploring these questions with a tentative hermeneutic of some of the prevailing interpretations of breastfeeding.

CHAPTER THREE: DISCOURSE DISCUSSION

> The hermeneutical situation means that we are up to our ears in historical, political, social, religious, sexual and who knows what other sorts of structures and networks, saturated by them, radically saturated, which is, of course, another way of saying that we are all wet and not too sure that we know what is what. (Caputo, 2000, p. 12)

Caputo prefaces the above quote with the statement that no matter how much the idealist might wish it, there is no simple way to wipe the slate clean and start an analysis free of the annoying complexities of life. In the face of the innumerable incommensurabilities of life, we are out of necessity required to do our best to "construe the traces, to follow the tracks and read the signs " (Caputo, 2000, p. 2). In order to examine truth in the nurse and breastfeeding dyad relationship, an immersion in those complexities is required. What follows is my attempt to acknowledge the complexities of breastfeeding and to the follow the tracks that lead back from breastfeeding in Canadian culture in the early twenty first century[2]. Following this discussion, I will briefly discuss and critique nursing's traditional approaches to examining truth.

Breastfeeding Discourses

Breastfeeding in nursing practice and literature is generally framed as a social good and also as a problem. The "problem" of breastfeeding for health professionals is despite decades of effort, breastfeeding initiation rates remain relatively constant at about 75% in Canada but the rates of those continuing to breastfeed drop markedly in the first weeks postpartum with only 38 to 41 % of children breastfeeding at three months postpartum (Canada, 1998). No current figures are available on the percentage of children breastfeeding until the recommended minimum of six months. My focus for this study is not the problem of breastfeeding; rather it is the nurse-patient (mother/baby) relationship and how a sense of

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[2] I acknowledge that this will be a North American centred discussion of breastfeeding, which is a limitation when considering the majority of mothers and infants in the world breastfeed under very different conditions and very different understandings than will be described here. The limitation is necessary to make the scope of this present discussion manageable.

truth arises for all parties. Therefore, I will not review the literature on the problem of breastfeeding.

The present discussion will trace some historical, scientific/biological, political, economic, gender, social and embodied discourses around breastfeeding. Although the discourses will be discussed as separate entities, they overlap, intersect, meld and cannot neatly be excised into compartments. The discourses represent the extant knowledge on breastfeeding and are a crucial component of the dialogue that will occur between them and the particular life situational events that are experienced in nurses' practice with breastfeeding mothers. A component of the actual work of the dissertation will involve an in depth conversation between the discourses that arise from the working together of the nurses and breastfeeding mothers and infants.

I have chosen to use the term discourse because the term points not only to the how the words are used but also the power of words in shaping our thinking and our consequent "realities". Discourse is the way of speaking and writing within a larger social context that reflects and reproduces the ideological structures at play. In this instance, discourse refers to how ideas and beliefs are constructed to sustain, enforce, and privilege some understandings and how some positions and comments are thus facilitated and others inhibited (Thorne, Kirkham Reimer, & Henderson, 1999). Discourses are presented as "truths" and tend to be univocal in denying space for the existence of other perspectives.

The Current Scene

Breastfeeding a baby is an ideologically laden endeavor. A cursory overview of the language used to discuss breastfeeding demonstrates the emotionally charged nature of the topic. Emotion tends to hide and color the complicated discourses that surround breastfeeding in our current culture. The following quotes from websites are included to demonstrate extremes of the contrary and conflicting contemporary cultural messages, meanings, and interpretations of breastfeeding that exist.

"The decision to breastfeed is not merely a lifestyle choice, but a moral decision with moral consequences for our children, families, Church and culture" (Walker, 1999). In this quote it is obvious that religion, righteous living, and representations of motherhood are closely linked in accordance with God's plan. Breastfeeding is not only about nutrition or nurturance, it is also about morality. Despite this rhetoric, the article is

also a call for a less consumptive and more integrated relationship with the Earth, by using a readily available resource instead of one that had to be manufactured, packaged, transported, and sold. On first reading this article puts the onus of responsibility for righteous living on the breastfeeding mother but the author also acknowledges the importance for societal supports and the role of all members of the church to create these societal supports for women to breastfeed.

To portray another extreme - "It's national breastfeeding awareness week - and the moralists have got the teat between their teeth" (Bristow, May 14, 2003). The second quote assigns the term moralist to anyone who promotes breastfeeding, not only those breastfeeding advocates like Mary Walker from the first quotation who frame breastfeeding in terms of morality and virtues. In Bristow's article anyone who advocates for breastfeeding becomes a moralist when they speak in support of breastfeeding. Bristow believes that advocating breastfeeding is about taking away women's choice and that breastfeeding advocates endeavour to make mothers feel guilty about their choices. In our individualistic and dualist society, choice trumps every other consideration. The advocates' strategies are obviously experienced as oppressive as the terms Nipple Nazi's, or Breastfeeding Police or Nazi's (referring to advocates of breastfeeding) imply (Bartlett, 2003; Hausman, 2003). Terms such as these are further examples of polarizing language present in discussions of breastfeeding.[3] The ambivalence that is the reality of most breastfeeding mothers' experience (Blum, 1999) is lost in each of such polarized renderings of infant feeding. Such ambivalence is understandable in a culture that both reveres scientific knowledge *and* views mothering as natural phenomenon (Hausman, 2003).

The above telling comments demonstrate the dichotomy that tends to occur in discussions of breastfeeding – it is either about the mother's choice, dismissing all recommendations to breastfeed as a medically sanctioned cultural and social imposition

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[3] In response to these very charged labels from their opponents, some breastfeeding advocates have shifted to an exaggerated portrayal of their beliefs [see The Militant Breastfeeding Cult (Little, 2002) or Hawthor The Cow Goddess (Cushman-Dowdee, 2004)]. The ironic humor in these over the top portrayals of themselves serve to demonstrate the stringent nature of their critics' comments about breastfeeding supporters. However, taken literally they may also reinforce their critics' beliefs.

on mothers designed to encourage guilt. Alternatively, there is an overarching sentiment that it is the baby's needs and indirectly the larger societies needs that take precedence over the mothers' thoughts or desires. The following discussion of breastfeeding discourses will attempt to illuminate a multiplicity of current perspectives on breastfeeding. How do nurses and mothers navigate these deeply polarized views with other health care providers, with other mothers, and with the general public?

A deep reading of the scientific and lay literature demonstrates that people will simultaneously take and hold firmly to a number of opposing ideals about breastfeeding and motherhood. The contradictory beliefs and practices about breastfeeding initially appear as a maze with no way to the other end, only false starts and dead ends. The conflicted views about breastfeeding and mothering encapsulate what Caputo has labeled 'life's original difficulty' and seem a viable entry point for a radical hermeneutic of truth (discussed in more detail in Inquiry section) in nursing practice relationships. How do nurses begin to honor the complexities of the ambiguities in people's experiences, advocate for health, and be responsible to their profession, their managers, organizations, institutions, and governments that place demands on their practice? What does it mean for nurses and patients to enter into the flux of this maze? What is the meaning of truth? What does it mean to search for truth in this context?

It is in the midst of this emotion and rhetoric that the nurse enters into a relationship with the breastfeeding mother. As one public health nurse noted, "Because I'm dealing with food and motherhood, everything is controversial" (MA, personal communication March 9, 2004). The nurse and the breastfeeding dyad represent a challenging relationship from whichto negotiate truth and shared meaning. It is also an important relationship. Breastfeeding is a significant life event for both the mother and infant that has health, social and political consequences. How does something so deceptively simple and "natural" as breastfeeding show up all these discourses?

Historical Representations of Breastfeeding

The following section will include an examination of historical representations of breastfeeding, since bodily practices are always historical (Blum, 1999) and culturally mediated experiences rather than biologically stable phenomena (Carter, 1995) . Bodily practices arise out of and occur in a context. Thus understanding the historical evolution

of the representations of breastfeeding is important for our understanding of breastfeeding at the beginning of the 21st century. Further, analyzing the representations of infant feeding throughout history can lead to important understandings of the challenges that mothers and the nurses that care for them currently confront in their discussions of breastfeeding. Since breastfeeding controversies are embedded in larger social conflicts about women as mother, representations of mothering will also be discussed. These representations or discourses demonstrate how deeply conflicted our culture is about the ideas and ideals of mothering (Hausman, 2003) and by extension breastfeeding.

A disclaimer – "any history of breastfeeding negotiates a contested terrain with its own sources" (Hausman, 2003, p. 10) and my attempts at negotiating this contested terrain are preliminary. Two dominant themes are evident in the breastfeeding literature – a perspective that is primarily biological in nature and treats politics as a neutral force and another perspective that highlights ideology and politics and downplays biology. In the majority of my sources, one of these themes is highlighted at the expense of the other.

The history of infant feeding shows varied and complex feeding practices have always existed. Feeding practices were influenced by a number of factors including geography, the place of women and children in particular economic and social systems, the women's physical condition, and particular beliefs about child rearing and mothering (Carter, 1995; Fildes, 1995). Some cultures placed a high value on babies and lactation, for example, in Babylon and Egypt babies were traditionally breastfed for about three years (Baumslag & Michels, 1995). Other cultures such as the Greeks and Romans placed much less value on lactation and children and the responsibilities for breastfeeding were primarily allotted to wet nurse slaves (Fildes, 1986)). Plato recommended the rearing of children in crèches by wet nurses and further encouraged that no mother should know her own child (Baumslag & Michels, 1995).

As humans began to domesticate plants and animals, a variety of substances other than breastmilk were used for infant feeding. Artificial feeding and dry nursing [4] became

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[4]Artificial feeding refers to all substances other than breastmilk and includes cow, goat, pig and dog milk. Dry nursing refers to the use of substances such as flour, bread or cereal usually cooked in the form of gruel to feed infants (Fildes, 1995).

more common. Some cultures abandoned breastfeeding in spite of greatly increased rates of infant mortality[5]. A variety of feeding, animal milks and gruels have been used through out history (Fildes, 1986; Van Esterik, 1995) and continued to be used to delay and replace breastfeeding (Baumslag & Michels, 1995; Morse, Jehl, & Gamble, 1992).

Prior to the eighteenth century little was written about pregnancy, childbirth and lactation. Information about breastfeeding and child rearing were received from family and women in the community in the form of oral advice and lore. An exception to this is the written male exhortations to breastfeed and condemnation of women who don't. This can be found throughout history. (Kessen, 1965) notes "The running war between the mother, who does not want to nurse and the philosopher-psychologists, who insist they must, stretches over two thousand years " (p. 1).

Eighteenth Century

The eighteenth century is notable for the shift from woman-to-woman transmission of breastfeeding knowledge to an emerging prominence of male medical advice about breastfeeding and all aspects of mothering. This shift coincided with the invention of childhood and the corresponding construction of bourgeois motherhood in the 17th and 18th centuries (Perry, 1991). These cultural rearrangements had their origins in the Enlightenment belief in the rational manipulation of forces of nature (agriculture, manufacture, trade and in this instance the family) for greater productivity.

In an epoch that was known for sweeping clean all socially determined differences among humans, the highlighting of women's biological difference was effective in offsetting women's potential claims to equality. Virtue linked to physiological activities such as breastfeeding and childbirth defined the ideal female. At the same time these physiological processes increasingly came to be seen as something scientists could interpret best (Perry, 1991). It was the beginning of sustained male intervention in the physical body and acts of women that coincided with women's

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[5]Estimates of the mortality of dry nursed infants were generally much higher than of breastfed infants, usually because of unsuitable foods and poor hygiene. Reported rates of mortality for dry nursed infants ranged from 50 to 90 per cent (Fildes,1995). Also see Hastrup (1992) for a discussion of infant feeding in 17th and 18th Century Iceland. Here farm produce came to be associated with womanly values – so instead of children being breastfed they received dairy milk and cream from birth.

exclusion from the public world (Carter, 1995). Upper and middle class women were chastised for failing to nurse their children and wet nursing declined. Breastfeeding shifted from paid labour for lower class women to unpaid reproductive labour for the middle class (Blum, 1999).

The increased emphasis of the maternal aspects of the breast was accompanied by a desexualization of the breast. Non-productive forms of sexuality were increasingly devalued and displaced during this period (Perry, 1991). In the eighteenth century maternity and maternal self-service came to be seen as a desirable counter to sexuality and put in opposition to individual expression and desire. The paradoxical ideal of the asexual mother arose at this time. By the mid eighteenth century women had come to be seen as without sexual interests, morally pure and self-sacrificing (Perry, 1991). Even today the sexual lactating mother is silent in most portrayals of motherhood (Bartlett, 2002b)

Nineteenth Century

The defining feature of the nineteenth century was the Industrial Revolution and the shift from an agrarian to market based economy. The shift furthered dichotomies between home and work and the labour of men and women. The ideology of domesticity which rationalized woman's position in the home arose out of this division of roles (Hughes, 1990). There was increasing emphasis on the maternal breast as the nurturant Centre of family life and the home (Hausman, 2003) and the virtuous mother who was responsible for maintaining home as a refuge from the world of work.

Differences in class resulted in the working class women lacking the economic means to enact the idealization of motherhood. The economic realities of working class women in urban areas required them to work outside the home. This resulted a marked difference in infant feeding methods between working class women in urban and rural areas. Breastfeeding rates in England and Europe remained relatively stable amongst rural women. However, working mothers in urban areas often did not breastfeed at all. Mill towns that had large numbers of women working had some of the highest rates of infant mortality that were attributed to mothers not breastfeeding (Fildes, 1986).

By the mid nineteenth century doctors began to suspect that middle and upper class women lacked the stamina to withstand childbirth and required anesthesia. They

also concluded that these women found breastfeeding more difficult (Golden, 1996). There was widespread skepticism that persists to this day about women's ability to produce appropriate and sufficient milk. By the late nineteenth century, the germ theory of disease and Pasteur's discoveries had made bottlefeeding safer (Blum, 1999). It was at this time that dairy milk began to be distributed, along with encouragement to breastfeed in urban health clinics. Ironically practices that were designed to encourage breastfeeding occurred simultaneously with actions that led to its diminishment (Hausman, 2003, Blum, 1999).

Twentieth Century

The medicalization of infant feeding was a well entrenched cultural practice by the early twentieth century (Blum, 1999; Van Esterik, 1995). Physicians' motives were both humanitarian and self-interested. They were concerned with infant death and disease as well as the safety of widely marketed infant foods. They were also concerned with claiming new professional terrain, status, and income (Apple, 1997). Their practices however were dependent on research and training that focused on what to do when things went wrong and on imitating the contents of breastmilk (Blum, 1999). They had little knowledge of normal breastfeeding physiology, patterns and variations.

By the 1930s scientific advancements made it possible to grossly determine the composition of breastmilk. Physicians began to promote the scientific composition of physician prescribed infant "formulas' for individual infants. The general perception of great value in all things scientific, furthered the superiority of artificial milks in the minds of the general public (Quandt, 1995). As artificial formula became safer, the bottle became the emblem of modernity, progress and autonomy for affluent women (Blum, 1999). The introduction of artificial infant feeding actually de-skilled women in breastfeeding and reinforeced the role of physicians as expert in the care of children (Sandelowski, 2000)

For those who did breastfeed, Millard (1990) characterizes twentieth century breastfeeding protocol as a factory modeled regime with the clock as the primary frame of reference and an emphasis on efficiency. The regimes were inherently mistrustful of womens' and babies' bodily signals and based on the desire to control all dimensions of the feeding experience. Mothers were advised to weigh before and after feeding and to

supplement with formula. Few doctors understood that breastmilk production is user driven, and that reduction of suckling (when supplemented with formula) would reduce breastmilk production. "Insufficient milk" became the most prevalent reason for breastfeeding failure. Physicians came to regard the resulting decrease of the milk supply as normal and inevitable (Blum, 1999).

Mothers and physicians were also influenced or "medicalized" by the emerging discipline of child psychology (Blum, 1999). The psychologists' goal was to develop a rational approach to child rearing and the development of habits conducive to achieving adulthood (Blum, 1999). This involved strictly regulated activity, and warnings against rocking and cuddling the infant to avoid dependency and potentially rewarding the infant for bad behavior.

By the mid twentieth century, breasts were becoming increasingly sexualized (Blum, 1999). Breasts were a powerful symbol of heterosexual sexuality in the post war years that women were expected to both conceal and display (Yalom, 1997) and there were clear prescriptions about when, where and whom could view a bare breast. There was also an increasing taboo against women nursing in public (Hausman, 2003). In the 30s to 50s there was greater emphasis on love, sex and marriage. Changing perceptions of the family resulted in women's increasingly close relationship with their spouses and increasingly distant relationships with their children. Breastfeeding was no longer merely a maternal duty when the breast began to have potential for pleasure.

By the 1970s, women increasingly demanded to operate in a civic world and in a waged labour force (Hausman, 2003). Yet any deviation to the male work cycle is costly in labour terms (Galtry, 1997), making it difficult for many women to breastfeed and work. At the same time there was a revival in breastfeeding associated with feminist activism around reproductive rights and a linking of the "counter culture and "back to nature" social movements with breastfeeding. Breastfeeding predominately became the preference of middle class, well-educated segments of the population, which remains the case today.

What is obvious from this historical review is that there was no clear trajectory in infant feeding practices from its earliest times to the present. A myriad of social, cultural, racial, class, political, religious and economic forces coalesced at each time period to

influence feeding practices. The same forces operate today. The next section will consist of a delineation of some of the major discourses circulating about breastfeeding and mothering today.

Current Discourses

None of the discourses elaborated below can be considered simply as oppositional, accepted or even as the dominant discourse. As the discourses are interrelated, the distinctions between the discourses have been arbitrarily assigned. Discourses must be considered:

> … as a multiplicity of discursive elements that can come into play in various strategies... [There is] a complex and unstable process whereby discourses can both be an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance, and a starting point for an opposing strategy. (Foucault, cited in Gore, 1998, p. 56).

Various standpoints taken by those interested in breastfeeding (e.g. feminist academics, breastfeeding advocates) tend to privilege certain discourses over others. However, there is no inherently representative or comprehensive breastfeeding discourse for women, children, or nurses, for all discourses have the capability to oppress and enlighten. Discourses can only be examined for their contributions in the particular and individualized historical and social context of interest. My challenge in the following segment is to provide an overview of some common discourses currently operating and in doing so, not mask the 'original difficulty' of breastfeeding for mothers or nurses. The discussion of the discourses will also assist in raising further questions that will guide the research.

Scientific/Biomedical Discourses

Basic to all scientific/biomedical discourses is the argument for the biological benefits of breastfeeding over artificial infant feeding substitutes. These benefits relate both to the benefits of breastmilk, the substance and the practice of breastfeeding. The scientific discourse around breastfeeding has a number of major arguments. They include: 1) mammalian milk is species specific meaning that it has characteristics that are particular to the nutritional needs of human infants; 2) breastmilk contains immunological properties unique to the breastfeeding relationship; 3) the social relationship between

mother and infants that develops through breastfeeding confers advantages on children who breastfeed. Basic to this is argument is that while artificial infant foods can replicate basic elements of breastmilk, artificial foods cannot replicate the complicated components of child specific breastmilk that are conferred as a result of the physiological and intersubjective relationship of the mother and infant (Hausman, 2003). These arguments are supported by a mass of statistically significant studies that suggest the biological benefits of breastfeeding. The scientific discourse arguments are summarized in the breastfeeding advocacy statement that "breast is best".

Health benefits accrue from breastfeeding for both the mother and infant. Breastfed infants are less likely to become ill than infants feed artificial food. Specifically they have a lower incidence and less severe occurrence of diarrhea, respiratory tract infections, otitis media, pneumonia, urinary tract infections and invasive bacterial infections (Lawrence & Lawrence, 1999). Less clear are the linkages to the prevention of chronic disease such diabetes, asthma, atopic dermatitis, and food allergies. Breastfeeding may also help prevent sudden infant death syndrome (SIDS) (Health Canada, Canadian Institute of Child Health, & Society, 1999). Some researchers claim that breastfeeding confers a small but clinically significant effect on intelligence (Dettwyler, 1995). Research on the health benefits of breastfeeding for women is relatively new and lacks consensus. There may be lower risks of premenopausal breast and ovarian cancer and it may have a positive protective influence against osteoporosis.

The scientific/biomedical discourses assume a certain self-evident belief in the power of scientific ideas to guide a social practice like breastfeeding (Hausman, 2003). A corollary assumption is that science alone should be the sole arbiter of human feeding practices, thus scientific support for breastfeeding often obscures the social, relational and political dimensions of infant feeding.

The "scientific" rational discourse to breastfeeding is prevalent in most health professional literature. Despite describing breastfeeding as a biosocial practice most journals reflect only those dimensions of breastfeeding that can be captured quantitatively and statistically. A review of the Journal of Human Lactation, the journal of the International Lactation Consultants Association (ILCA) from June 1997 to the present reveals a bias towards the biological and technical aspects of breastfeeding. Out of the 28

journals reviewed (including 112 research articles and 10 columns focusing on lactation consultant practice), only four articles focused on the relationship between the health care professional and the breastfeeding mother or social support for breastfeeding mothers. The prevalence of the scientific discourse serves to marginalize other views of breastfeeding and is not reflective of the actual practice of lactation consultants with breastfeeding mothers.

Central to biomedical/scientific discourses about breastfeeding is the idea of scientific motherhood (Apple, 1997). Scientific motherhood reflects the cultural agreement that in order to be good mothers women must be guided by scientific advice and subjugate their own perspectives to the authorities or experts. This is parallel to Davies-Floyd and Sargent's (1997) use of the term "authoritative knowledge" in childbirth. Authoritative knowledge gives primacy to the voice of experts. Authoritative knowledge also makes the voice of mothers seem unnecessary, unimportant and leaves expert knowledge unquestioned. In this model, physicians (and other health professionals) have a responsibility for correct practice and education, while individuals and the community should be passive recipients of services and advice (Van Esterik, 1989).

The passivity of the patient is evident in the term medical practitioners use to speak of their practice with breastfeeding mothers - the "management" of breastfeeding. The "management" of breastfeeding is a term that reflects the control, efficiency and production ideals of both modernity and globalization. Use of this business-oriented term for a practice that is not commodified and largely occurs out of the direct control of health care practitioners is telling. The etymological roots of management come from the sixteenth century and refer to the training of a horse, and the action and paces that a horse is put through (from the Italian *maneggio,* and the French *manage).* In the seventeenth century, the term began to be used to refer to humans and meant to control. Maternal child health care practitioners, especially medical doctors', use of the term management of breastfeeding implies that experts (persons not involved in the physiological act of breastfeeding) can actually control an unpredictable activity between two human partners.

Although physicians and other health care professional mediate the scientific evidence concerning health, many health professionals do not know how to practically assist women with breastfeeding, nor do they seem to be aware of the misinformation about breastfeeding that they provide (Hausman, 2003). Breastfeeding advocates who see misinformation as a major contributor to women discontinuing breastfeeding frequently have identified that health professionals perpetuate a "breastfeeding culture of misinformation". Lawrence and Lawrence (1999) in *the* reference book for physicians *Breastfeeding: A guide for the medical profession (5th Edition)* describe the medical management of breastfeeding. They are actually speaking about managing the mother-infant nursing couple in a society that continually misunderstands lactation. The authors' intent is also to manage physicians who continue to perpetuate misinformation about breastfeeding.

Although many health professionals give lip service to breast is best, they lack the practical wisdom to assist women to successfully breastfeed. Breastfeeding advocates, both health professional and lay, have had only small successes in changing this culture. It's an ironic situation where those attempting to manage women's practices have not been successful in managing the practice of their professional peers. Hausman (2003) summarizes this irony " the medicalization of infant feeding… has had particularly ambivalent effects on the cultural construction of breastfeeding because medicine both promotes breastfeeding *and* often mishandles it in practice" (p. 22).

The evolutionary discourse is a parallel anthropological argument, used in conjunction with the scientific evidence of the benefits of breastfeeding, to describe the "naturalness" of breastfeeding. The underlying argument in the evolutionary discourse is that environmental conditions in our evolutionary development shaped humans physiology and biosocial practices. In the case of breastfeeding this means children were raised close to their mother with frequent contact and suckling and late weaning. Prolonged nursing resulted in child spacing that ensured optimal intervals for child survival (Dettwyler, 1995). This discourse is often used to support mothers' breastfeeding and a scientific rationale for encouraging specific infant feeding and child care practices such a late weaning, frequent infant contact and infant led feeding.

Unfortunately this discourse may not have the desired effect of having more mothers breastfeed. The case for raising children as they were treated 400,000 years ago actually can act to associate breastfeeding with primitive behaviour and frame breastfeeding as inadaptable to modern life. In a sense the evolutionary argument asks women to conform their social practices to the demands of their bodies and their infants. In our modern culture where we adapt the body to fit the cultural ideals, there is not much capital in being asked to conform to the demands of the body. As well the practices that the evolutionary proponents advocate are only possible for a select group of women in North America - middle class or wealthy women. This is also the group that has the highest rates of breastfeeding. The evolutionary discourse marginalizes women who are not economically privileged or white and who lack the same resources to access health care as their middle class counterparts.

Also inherent in this evolutionary discourse is the implication that only the female body is prisoner of its history. Unlike women, the male body does not seem to be hampered in modern life at all by its evolutionary expectations. The evolutionary perspective enshrines the bodily difference and greater reproductive burden of women but does nothing to address the inequities that arise or the power that accrues to men because these differences. On its own the evolutionary perspective becomes linked to moralistic discourses about maternal responsibility.

Discourses about the scientific/biomedical discourses.

There are two views of the scientific discourse for breastfeeding. A number of feminist scholars are most concerned with the pressure placed on women to breastfeed. They see scientific arguments in favor of maternal nursing as primarily political. They distrust scientific information because science has long promoted essentialist and deterministic approaches towards women. Thus all medical arguments are seen as problematic and untrustworthy (Hausman, 2003). Scholars such as Linda Blum (1999) and Pam Carter (1995) hold the perspective that breastfeeding is best understood in an analysis that emphasizes the political concerns while repudiating the scientific concerns. While they acknowledge that breastmilk might be biologically superior for infants, they argue against this as the primary determinant for mother's choice of feeding methods. While acknowledging the vast impact of social and political constraints on women's

lives, they effectively refuse to acknowledge that biological discourses have anything to contribute to conversations about breastfeeding. Although they critique health professionals for overemphasizing the benefits of breastfeeding, their view would seem to underemphasize them. Feminist critiques such as these make it difficult to make a case for the public health benefits of breastfeeding (Hausman, 2003).

The alternative discourse is that of the breastfeeding advocates who utilize the scientific discourse to promote breastfeeding. In the scientific discourse the female biologic capacities and practices are often conflated with women's social roles and the scientific discourse is thought to promote a conservative normative view of mothering. The scientific view of mothering also increasingly brings women's practices and experiences under medical scrutiny. For the physician to monitor the feeding of an artificial formula does not require the same regulation of the mother as breastfeeding does. In breastfeeding under the medical gaze, the mother is managed as much as the infant (Hausman, 2003).

The scientific discourse is also associated with maternalism –which Blum (1999) has described as the belief in fulltime mothering or in immersion mothering such as promoted by the La Leche League (LLL). The maternalist viewpoint promoted by the LLL is viewed as suspect because it doesn't challenge the sexual division of labor but works within that division for mothers and babies and is based on a conception of two parent family. Some feminists view advocacy of scientific discourses as adherence to traditional domesticity ideologies and being unresponsive to the social and financial realities of most women with young children.

Both discourses about scientific/biomedical discourses frame it as an either or situation. To some, accepting scientific evidence means giving up on politics, while the scientific discourse does not have to be linked with traditional role divisions and biology is destiny thinking. The scientific discourse could be used to acknowledge women's greater reproductive burden and to press for women's social and political right to breastfeed and to push for policies that support mothers to do so.

What scientific/ biomedical truths about breastfeeding direct and trouble nursing practice with breastfeeding mothers and infants? How do mothers and nurses interpret the scientific/ biomedical discourses? How do the discourses impact nurses and mother

engagement and search for truth? How do competing discourses influence inter-professional relationships and consequent relationships with breastfeeding mother and baby? What are the ethical complexities of breastfeeding support and advocacy? How is truth revealed in the midst of competing discourses?

Political Discourses

> Breastfeeding…cannot be understood without reference to varying levels of analysis including individual, household, community, institutional and world industrial capitalism. As much a part of self and identity as political economy; as personal as skin and as impersonal as the audit sheets of multinational corporations, breastfeeding research requires a synthesis of multiple methods and theoretical approaches.
>
> (Van Esterik, 1995, p. 163)

Although many would like to believe that breastfeeding is not political and wish to relegate it to the private space of the home (Bartlett, 2002b), as Van Esterik points out it is impossible to draw boundaries and sever breastfeeding from being part of the web of social values, gender beliefs, government policies and economic conditions, Even those who wish to portray breastfeeding as a matter of personal choice are making a political statement about individualism, about scientific discourses, and about their personal understanding of the workings of society.

Thus every stance taken has political dimensions and "it is politics that determines which truth is heard" (Van Esterik, 1995, p. 165). The previous discussion of the discourses that circulate around the scientific evidence for breastfeeding further demonstrate political nature of breastfeeding representations. In the following section I will limit the discussion to three discourses: one a well known political movement and its related discourses, the second a submerged discourse, notable because it does not register prominently in the collective conscious, and the third a discourse that is a marker of our consumer culture.

Breastfeeding was politicized on a worldwide scale in the 1970s and 1980s with the efforts of an international group of activists to stop the unethical marketing of artificial baby milk (Blum, 1999). The Nestlé boycott was a prime example of "truths"competing to determine which "truth" would be heard and gain credence. In

infant feeding, the goals of private profit and public health are at odds (Baumslag & Michels, 1995). From a public health perspective, babies' growth and development needs are best met when it receives nutrition and immunological benefits of breastfeeding. The goal of the baby food industry is to maximize its market by increasing the number of mothers who use their products and the length of time they use them. Through massive marketing efforts and dissemination of often inaccurate and misleading information, the formula companies created a burgeoning new world market. Their strategies included enlisting health care workers and hospitals to expand their consumer market. The formula companies were successful in creating a meaning for formula beyond its functional value. Formula became a source of status as it was linked with westernization and modernization (Van Esterik, 1989).

As formula sales soared and new disease occurred – " baby bottle disease" – a cycle of diarrhea, dehydration and malnutrition resulting from unsafe, unhygienic diluted feeding methods. A majority of world health workers, physicians, and missionaries grew alarmed at the rates of severe malnutrition and death in bottle fed babies (Baumslag & Michels, 1995). In 1970s and early 1980s national advocacy groups throughout the world provided evidence of unethical marketing of infant formula. North American church and social justice groups exerted pressure in the boardrooms of the major formula companies. In 1977, IBFAN (International Baby Food Action Network) initiated a consumer boycott of Nestlé asking it to stop its aggressive marketing practices. Nestlé responded by instituting a one million dollar advertising promotion to religious bodies denying its marketing practices were problematic. The boycott continued, launching Congressional hearings in the US, and garnering worldwide publicity and support. It is estimated that the boycott cost Nestlé $1.1 billion (Baumslag & Michel, 1995). Ultimately the WHA (World Health Assembly) was convinced that a regulatory code for the formula industry was necessary. In 1981, the WHO International Code for Marketing of Breastmilk Substitutes was adopted (Van Esterik, 1995).

Both the US and Canadian governments have refused to enforce the Code, preferring to rely on voluntary compliance by the formula companies. The formula companies have apparently effectively lobbied the governments to believe that infant feeding can best be conceptualized as a consumer rather than a health policy issue. In the

early 1990s the Baby-Friendly Hospital Initiative (BFHI) became a worldwide movement in support of the Code. Both the US and Canadian governments have neglected to implement policies that would encourage compliance with the BFHI (Hausman, 2003). Although the Code bans advertising of breastmilk substitutes and no free samples and no promotion of products through health care facilities - many hospitals in Canada receive free formula from the companies, and some hospitals still routinely send mothers home with formula. The formula companies now market directly to mothers in their homes – sending formula, Teddy bears and rebate checks. Direct home marketing is a costly endeavour but the payoff in formula brand loyalty is lucrative.

The politics of breastfeeding are not related to marketing abuse alone, but are also embedded in questions about the status of women, poverty, corporate control over food supply and environmental issues (Van Esterik, 1995). A discourse that is seldom mentioned is the environmental impact of breastfeeding. I choose to include this discourse because it highlights that breastfeeding is more than just an individual choice with ramifications only for individual babies, mothers, and families. Breastfeeding also speaks to our interconnectedness with the Earth.

All human practices including infant feeding have an impact on the world ecosystem. Despite infant feeding being a universal activity, nurturance and infant feeding are not generally linked to sustainable development (Van Esterik, 1989). Breast and bottle feeding have very different implications for the future environment. Breast milk is a unique renewable resource, a product that increases in supply in proportion to the demand. It is a highly individualized process adapted to the needs of both the mother and the infant. The infant actually "controls' its own food supply (Van Esterik).

Bottle feeding with formula is a non renewable resource that uses more nonrenewable resources to produce and prepare. It uses fossil fuels in its production and produces solid wastes. It is a standardized product that is not responsive to individual needs and can be adulterated in its production. In the instance of formula feeding, the infant is a passive consumer from birth (Van Esterik, 1989).

The delinking of infant feeding from environmental and community consequences serves a number of political purposes. It promotes the economic model of the world over views that acknowledge and support our human interconnectedness and our connection to

the natural world (Smith, 2000). This separation serves to promote the commodification of a process can exist independent of the consumer products. When breastfeeding is seen as simply different but the same, its value is diminished.

Hausman (2003), in a review of pregnancy and infant care manuals, found that discussions of infant feeding are structured to present a symmetrical choice between equivalent methods. Although the beast is promoted as best, the portrayals in the literature imply "breast is best but formula is really just as good" (Hausman, 2003, p. 114). Even in texts that identify breastfeeding as more healthful for infants, the scientific evidence that supports the "breast is best" advice is downplayed or directly contradicted in the discussion of bottle feeding.

The delinking of breastfeeding from the environment further serves to bolster the political discourse of choice and autonomy – valued hallmarks of the consumer society. If feeding has no consequences in the larger world, then the choice to breastfeed really is just a matter of preference.

Economic Discourses

The most telling economic discourse concerning breastfeeding may be the absence of breastfeeding in most economic conceptualizations. Waring (1988), a feminist economist, describes the blindness in traditional economic accountings of what matters in the world. A woman working to haul water for drinking and crop irrigation to feed her family is considered unproductive by GDP standards because nothing is bought and nothing is sold. Yet a man working in a munitions plant building weapons of mass destruction is productive because he is paid and the weapons can be sold. Reversing this flawed accounting perspective, Australian economist Julie Smith estimates that breastmilk is worth about fifty dollars a liter and that Australian women produce about 2.2 billion dollars of breastmilk a year, contributing about .5 per cent of the GDP (cited in Giles, 2003). Norway is the only country to include human milk production in its reports of national food production.

The twentieth century represents the first time in history that huge industries have actively and aggressively promoted feeding options for women and profited greatly from womens' decisions not to breastfeed or to supplement with a commercial product (Van Esterik, 1995). Companies make huge profits from the sale of infant formula and

willingly spend large amounts on expanding their marketing. The discourse could best be described a "money talks".

The discourse about health versus profit is played out on the economic playing field. Enormous profits are to be made if breastfeeding is a mere choice and bottlefeeding can easily supplant it. Health professionals have become enmeshed in the economic spinoffs of formula promotion. What are the professional and ethical implications of health care professionals receiving money and other benefits from formula companies? It is difficult to see how the professional independence is not compromised by their relationship with the formula companies. The American Academy of Pediatrics (AAP) as of 1995 was receiving $1 million a year from formula makers (Baumslag & Michels, 1995). The industry also contributed three million dollars to the cost of building the Academy's headquarters in 1983. In a move of independence the Canadian Pediatric Society voted against accepting formula company money for educational sessions.

Our government is also complicit in the actions of formula companies. They have not ratified the WHO Code on the Marketing of Breastmilk Subsitutes and prefer to rely on a voluntary compliance by the formula companies. Without government sanction, there is no one except breastfeeding advocates monitoring violations and no penalties for violations.

Another economic discourse circulating in breastfeeding discussions relates income and breastfeeding. Unlike earlier eras where breastfeeding was the option of the poor, today breastfeeding is primarily a middle class phenomenon. It is well-educated, middle class women who are most likely to breastfeed and breastfeed for longer periods of time. The lowest rates of breastfeeding are among the poorest women. Galtry (1997) notes that "those in the most disadvantaged positions in the labour market are, in general, the most constrained in such choice [infant feeding]" (p. 1). This statement effectively discredits the political discourse of choice – which assumes a level playing field that does not exist.

Gender Discourses

Although feminist practice of childbirth (e.g. - legalization of midwifery services, more women-centred birth practices in hospitals) has developed over the past two

decades there has not been a parallel development of a feminist breastfeeding practice (Carter, 1995). Perhaps this has occurred because most women, with notable exceptions[6], retain their independence and autonomy during pregnancy and the birth is a relatively short event that is more amenable to systemic change to support women's experiences (Blum, 1999). Breastfeeding, more than pregnancy, represents women's heavier reproductive burden (Hausman, 2003).

Breastfeeding, because of the addition of the nursing infant and the intensity of the relationship required, has proved more challenging for feminists to address. Feminists have struggled to develop a supportive, inclusive stance towards breastfeeding as part of women's experience. For example, a number of feminist authors during the last decades of the 20th century indicated that bottle-feeding held the promise of women's liberation and that breastfeeding was neither a necessary or preferred choice. (Bem, 1993; Chodorow, 1978; Heilbrun, 1986).

The majority of feminist literature on breastfeeding portrays breastfeeding from a dualist standpoint. The choices for women appear to be minimize their gender differences in order to travel the path to liberation and thus look to technology or science for options that will free them from these differences or fight to remove the constraints put on them by patriarchy (Carter, 1995). Efforts to highlight difference between the genders and promote difference – such as the evolutionary perspective of breastfeeding have been seen as regressive and the promotion of breastfeeding has often been conflated with promotion of traditionalist roles or domesticity for women. To advocate for breastfeeding in some feminist views is to advocate for maternal sacrifice and the dismissal of mother's autonomy in the body of her children.

Others believe that the promotion of breastfeeding in the form of real material support for women of all races and economic classes in society to breastfeed would be a significant indicator of movement to gender equity and should be pursued.

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[6] These exceptions include women receiving the controversial order of bed rest for a variety of conditions in pregnancy (Maloni, Cohen, & Kane, 1998); drug addicted women who been charged with a variety of criminal charges from child abuse to homicide (Tillet & Osborne, 2001); women ordered to undergo c-sections against their will (Cahill, 1999); and those who have been ordered to have blood transfusions when denying consent (Levy, 1999).

Social Discourses

One of the most common social discourses about breastfeeding is the discourse of the bad mother. Rhetoric about the bad mother can be conjured regarding mothers breastfeeding in public spaces (Bartlett, 2002), or mothers failing to supply sufficient nourishment when breastfeeding and failing to notice the subsequent decline of their child's health.

Hausman (2003) contrasts the media coverage of Tabitha Walrond, a young poor black mother whose infant died from starvation when being breastfed, and the coverage of white breastfeeding mothers whose infants were identified as failure to thrive. Both these extreme instances highlight concerns about responsibility and mothering, work and mothering, and an overarching tension about mothers' judgment and good mothering. Perceptions of good and bad mothers allow black mothers and white mothers experiencing the same medical syndrome to be represented quite differently in the media.

A common discourse in both scenarios is that mothers can't be trusted, however middle class white mothers are most likely to be portrayed as victims of the medical experts "Breast is Best" exhortations and thus a victim of their own privilege (Hausman, 2003). Although Walrond received grossly negligent medical and bureaucratic care, she ironically was held responsible and not seen as a victim but as the holding the final responsibility for her child's welfare. In the case of the white mothers, who had the most resources and could most easily access the care and support they needed, the fault lay with the overly zealous medical experts who would recommend breastfeeding even to the detriment of the infant. Discourses about good and bad mothering in breastfeeding and contradictory images of mothering cannot be extracted from discourses about race and class (Hausman, 2003).

What representations of good mothering and bad mothering are evident in nurses' and mothers' conversations? How do these representations of mothering influence a sense of truth developing in the nurse-mother relationship?

Embodied Discourses

Bodies provide the condition and context through which humans relate to each other and to the world (Grosz, 1994). In the case of breastfeeding it is the embodied baby, meeting the embodied mother and the embodied breastfeeding dyad meeting the

embodied nurse. Breastfeeding calls attention to every aspect of experience. Bodies do not only allow us to take action (feed children), they also can be the repository of dis-ease (engorged breasts, sore nipples, problems latching), and they also provide a perspective point for our very existence (Merleau-Ponty, 1998). It is through our bodily situation that we grasp meaning and encode our understanding of the world (Benner, 1994). Interpretation is therefore not just a mental activity; meaning is generated through the body situation. Understanding itself is embodied.

Breastfeeding as an embodied maternal practice has received little consideration as an academic or feminist topic. It is certainly a discourse that is ignored in the medical management of breastfeeding, where a mother's body parts tend to be addressed as entities separate from the woman.

As breastfeeding establishes a radical physiological relationship between the mother and infant through the mother's body (Hausman, 2003), it presents a rare form of intercorporeality for study. Conceptions of female embodiment have typically been equated with male embodiment. The lactation relationship in breastfeeding makes it difficult to conflate the male and female embodiment experiences and can offer rich insights of embodied life.

What is the relationship between embodiment and truth? What would be an embodied truth? How does an embodied truth arise?

Drawing Together the Breastfeeding Discourse Discussion

Conversations about breastfeeding open up much larger conversations about women in society, about science and ideology, about work and home, about public obligations and private ones, about private decisions in a communal world. Nurses and breastfeeding mothers in their interactions are participating in all of these larger conversations and the competing worldviews they represent. Through the vehicle of nurses and breastfeeding dyads, I plan to examine the meaning of truth in the midst of the dynamic, conflicting world that is our home.

Nursing Discourses

NURSES

We speak with our eyes, we teach with our hands, we comfort with our presence.

The above words are printed on a poster my family gave to the nurses who cared for my dying father. The words of the slogan resonate with me with me still because they hint, perhaps in romanticized terms, of the ineffable qualities of the embodied practice of nursing. They speak to me of truth, of something yet to be disclosed, of something rich and meaningful.

In contrast, the traditional and preeminent nursing discourses about truth do not resonant for me. Not only do they not address embodied nursing, they do not address truth in the context in which nursing occurs. I wonder: How has nursing narrowed its conversation with truth? How have we made the conversation so small that it is not a sufficient truth for nurses to live with?

As a product of modernity, the predominant nursing discourses about truth and conceptions of what constitutes truth have been shaped by the ideals of rationality and objectivity. These ideals were coupled with the political ideology of liberalism and its central tenets – individualism, freedom, egalitarianism, neutrality and the "free" market economy (Browne, 2001) and resulted in a nursing science founded on notions of abstract, freely choosing individuals who exist in an equitable society. A brief stop in any hospital ward illuminates that an equitable, neutral world with autonomous individuals freely making choices is not the world that nurses or their patients live in.

Nursing has been caught up modernity's disciplinary exhortation to find an explanatory and predictive theory and the "convenient fiction" that there was world "out there" waiting to be discovered and described (Schwandt, 1996). There was an underlying belief that truth and by extension knowledge lay in methodological adherence. This adherence has been coupled with the desire for certainty, a striving for resolution and a final answer. As Rawnsley (1993) noted "From the bedside nurse to the bureaucratic chief, there is a marked tendency to choose conclusion over reflection" (p. 2). Method provided the false assurance of a certain pathway to knowledge and truth. The outcome has been a kind of complicity in reproducing the status quo that has distanced the discipline from patients and its practice. Nursing developed an epistemic infrastructure that widened the gap between theory/research and the practice of nursing and privileged theory/research over practice in the development of knowledge (Cameron,

1998). This resulted in an instrumental account of knowledge that denied the situatedness of the nurse producing the knowledge as well as the nurse 'consuming' the knowledge.

Traditional empiric pathways to truth have not captured the spontaneous, the hidden and the unarticulated realities of nursing work and life. The inherent tendency of traditional forms of inquiry for reduction and distancing of subject-object, have resulted in oversimplified representations of nursing practice. Further the market model of health care and nursing has further misrepresented what actually happens in practice.

> Making sense of nursing situations when nurses are responsbile for its accounting (that is nursing as a mediated action) is a different kind of undertaking than making sense of nursing situations in the everyday world of illness, pain, fear, medical emergencies and so on." The accounting approach to nursing obscures and organizationally obliterates nursing knowledge and nursing action beyond that which is mediated and documented. Nursing sense making for situated, as opposed to textually mediated action remains a necessary if undervalued part of nurses' work and nurses' education. (Campbell, 1995, p. 232)

If the traditional avenues to nursing inquiry provide at best a cautionary tale, but do not speak in meaningful ways of embodied nursing practice in a complex and challenging world, how to proceed in my efforts at truth seeking?

CHAPTER FOUR
PATHWAYS TO UNDERSTANDING (METHOD)

The truth I am attempting to understand, that is the truth that occurs in the practice of nursing is experiential, dynamic, complex, messing, and multivocal and as such it must be examined by interpretative means (Jardine, 1998d). To address the meaning of truth in nurse-patient relationships and how they arise, must occur by methods that acknowledge the complexity or flux of life (Caputo, 1987, 2000). The following section provides an overview of hermeneutics and radical hermeneutics – the philosophical thinking that underpins and guides this research.

Hermeneutic Inquiry

Although hermeneutic insights can be traced back to antiquity, hermeneutics as a practice first emerged in the seventeenth century and was referred to as the science or art of interpretation. Its purpose was to render biblical text, art, and/or literature intelligible. (Grondin, 1994). To trace the antiquital beginnings of the term, it is useful to examine the Greek root word *Hermeneuen.* This word is probably derived from the name Hermes, a son of Zeus in Greek mythology (Graves, 2001)[7]. Hermes was often depicted in the role of messenger between the gods and mortals on earth and was associated transmitting what was beyond human understanding into forms that humans could readily make sense of. The word Greek verb *hermeneuein* originally had three senses: expression (speaking), explication (interpretation), and translation (acting as an interpreter) (Grondin). Each of three senses share the intent to convey meaning and together form a process of mediating meaning that moves to make the unintelligible comprehensible and understood.

Hermeneutics is a basic condition of human understanding (Heidegger, 1927/1996). The act of interpretation is involved in every facet of our existence in the world and involves not only ourselves but also that which we seek to understand. As reflective inquiry concerned with all modes of human understanding and experience of

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[7] Controversy exists between philologists as to the etymological link between Hermes and the semantic family of hermeneus. For further discussion of the controversy see Grondin (1994), p. 22. Grondin concedes that despite the controversy a better etymology has yet been found. I have included the Hermes etymological link here because as Smith (1999e) notes Hermes possesses other characteristics (playfulness, friendliness) that are important features of the type of hermeneutic endeavour I'm proposing to undertake.

the world, hermeneutics is central to any reflection on human experience in the world (Madison, 1997).

To engage in hermeneutics is to acknowledge that there is much that is not understood and thus requires us to cease taking for granted both words and actions. It calls us to deeply examine words and actions and to enter into a dialogue with their history, the cultures in which they arose, the multiple ways they have been conceived in human lives. Hermeneutic engagement requires that we become immersed in the evolution of meaning of words to their current context, their current conceptualizations and even the possibilities for their future usage. As Gadamer (1999) states "the claim of hermeneutics seems capable of being meet only in the infinity of knowledge, in the thoughtful fusion of the whole tradition with the present" p, 341.

If it is tradition that supplies the background and ground for understanding then language is the medium in which our relationship to the world unfolds (Gadamer, 1999). For Gadamer, human beings live in language like a fish lives in water (1997a) It is through language that we are given the world and through language that we come to know (Geanellos, 1998).

In its earliest days, interpretation of biblical texts had a normative function, laying out the rules that governed the discipline of interpretation (Grondin, 1994). Yet the hermeneutic tradition that has evolved since the mid 1500's has consistently been a reaction against constraining mindsets about human thought and understanding. Key contributions have been that no text can be understood apart from the community involved in its study and further that a work cannot be understood apart from the intention and composition of the whole.

Interpretation is always dialogical in nature. As Grondin (1994) states" to interpret a text means to enter into a conversation with it, direct questions to it, and allow oneself to be questioned by it" (p. 74). William Dilthey (1833-1911) described the purpose of hermeneutic science as understanding and distinguished it from the explanatory knowledge generated by natural science methods. He also emphasized the temporal and historical nature of human understanding.

Martin Heidegger (1889-1976) was possibly the most controversial philosopher of the twentieth century. Despite this controversy, his work is of particular interest as it lays

the groundwork for radical hermeneutics. Heidegger shifted the hermeneutic discussion from epistemological to ontological concerns (Bilimoria, 1998). To a significant extent Heidgegger's work was one of "deconstruction" in that it shuns essentialist and foundationalist thinking (Madison, 1997). He radically changed how understanding was understood. For Heidegger, understanding is not an entity in the world, but rather is the background from which humans operate in the world. Understanding precedes all action and meaning always proceeds being (Gelven, 1989). For example in the context of this research, the meaning of mother precedes all descriptions of the entity of mother.

Dasein or Being is "that on the basis of which things are already understood" (Heidegger, 1962 as cited in Dreyfus, 1996, p. 2). The shared practices of our socialization provide the inherent understanding of what it means to be human, what counts in our culture and what is the sensible thing to do in any circumstance (Dreyfus, 1996). All humans have this understanding, which allows us to engage with others and ourselves (Inwood, 1997). Understanding is therefore a pragmatic and existential matter (Caputo, 1987). Interpretation is the working out of understanding and " is the way that understanding gets developed, filled in and articulated" (Caputo, 1987, p. 69)

By saying that humans are Dasein, a "being-there", Heidegger rejected the notion of human beings as autonomous, rational and self-transparent subjects or actors. Unlike modernity's subject, Dasein's being is determined by the world and the circumstances in which we are always already thrown. Understanding is not a way that humans know the world, but it is rather what human beings are. Heidegger's position undermines modernity's claims to the universal "human" and the conception of "human" as endowed with definite properties and a stable identity (Caputo, 2000). He describes Dasein instead as an ability-to-be (*Seinkönnen*) and as an always unfinished product (Heidegger, 1927/1996).

As well as challenging the notion of subject, Heidegger provided a critique of objectivity. Western scientists have traditionally sought objectivity based on agreement between statements or theories and reality. From Heidegger's perspective the meaning we attribute to anything always results from the projection of a certain background of expectations, or from the beings placement in some realm of intelligibility. Since access

to reality is always mediated by a linguistic and conceptual template, objectivity becomes a mythical phantom.

Heidegger critiques the correspondence view of truth where a linear relationship is seen to exist between a true statement and an external reality "out there". For Heidegger there is no reality that is unmediated by language, experience or historical context. In correspondence theory, truth in located in the assertion. Assertions or statements are not truth in that truth does not dwell in the statement. He saw assertions as merely privileged derivations of the truth that distract us from our originary experiences. In Caputo's (1987) words: "We become lost in words and fail to enter into a relationship with the things themselves."(p. 75).

Truth is what enables us to make assertions at all. The quest for truth is not a search for certainty but a quest for disclosure of previously unknown realms. Before a statement can be made or understood, the world around us and the entities within it must be undisclosed to us (Inwood, 1999). Heidegger saw truth as "unconcealment" or "unhiddenness', the disclosing of what is concealed. Truth becomes a disclosure, an openness towards that which cannot be encompassed.

Radical Hermeneutics

As described in the above section on hermeneutic thought, hermeneutics has always had its critical, challenging and radical edge. Caputo (1987; 2000) coined the term radical hermeneutics. He traces the beginning of hermeneutics radicalization to the later writings of Heidegger. He then uses deconstructive criticism to push hermeneutics to its full radical nature. The radicalization of hermeneutics lies in the cultivation of "an acute sense of the contingency of all social, historical, linguistic structures, an appreciation of their constituted character, their character as effects " (Caputo, 1987, p. 209). The intent of radical hermeneutics a la Caputo is to return life to its original difficulty – to the flux – but "at the same time not make it impossible " (1987, p. 209).

What does it mean to return life to its original difficulty and what is the flux? Bergum (1991) has used the term " 'live' the question" (p. 67). The flux of life asks us to do just that, to not close down the questions of life and the challenges of being human with certainty and answers. Rather the original difficulty of life implies that life or Being is a source of never ending questions that deny the possibility of finite answers.

Heideggarian hermeneutics proposes moving beyond metaphysics that would conceal the difficulty of life with false reassurances. Derrida (the thinker most often associated with deconstruction) dismissed the notion of metaphysics as the reservoir of an ageless truth that could direct and console us. Metaphysical views ultimately close down questioning with an appeal to a higher ground or heavenly informer (Caputo, 1987). Radical hermeneutics denies the possibilities of universals and of certainty. Life can never be contained within these artificially constructed boundaries.

From Caputo's perspective, it is the role of hermeneutics to deconstruct the myth that human affairs can and should be formalized by the imposition of rules or theories about science, ethics, art and religion and about our relationships. A radical hermeneutic instead "exposes us to the gaps, ruptures, textuality and difference that inhabits our thinking, doing and dreaming" (Caputo, 1987, p. 6). In doing so, hermeneutics describes the human condition. Further it is hermeneutics role to show that human affairs without formalized explicit rules do not lead to anarchy and chaos. Caputo sums up his claim for a radical hermeneutic:

> It is the claim of radical hermeneutics that we get the best results by yielding over to the difficulty in "reason", "ethics", and "faith", not by trying to cover it over. Once we stop trying to prop our beliefs, practices, and institutions on the metaphysics of presence, once we give up the idea that they are endowed with some sort of facile transparency, we find that they are not washed away but liberated ….Far from abandoning us to the wolves, radical hermeneutics issues in far more reasonable and indeed less dangerous ideas of reason, ethics, and faith than those metaphysics has been peddling for some time now. Curiously enough, the metaphysical desire to make things safe and secure has become consummately dangerous. (p. 7).

This danger is evident in the tensions that are currently playing themselves out on the world stage (Smith, 2003). Underlying these tensions, described earlier in the paper, lays the ideal of emancipative reason. Although the purported defining feature of emancipative reason is liberty, the dangerous playing out of this ideology across the world, demonstrates that an extreme subjectivity and self-enclosure best explicate reason's nature. This extreme cognitive self-enclosure has resulted in an inability to

register the experience and suffering of those operating outside its ideology. This has resulted in inequitable, unjust, unfair and even murderous practices in the name of the "freeing" banner of emancipative reason. Smith summarizes: "Ironically this marks, the 'irrationality of the myth of modernity, and its powerful underside; the irrationality of total rationality" (p. 495). As Smith demonstrates in his critique, the uncovering and making explicit the difficulties in underside of reason is more liberating than our continued denial of its existence.

Radical hermeneutics advocates a sweeping withdrawal of foundations. What does this mean for knowing and action – for science and ethics? The call is for a deeper thinking of both ethos and knowing. Removing the metaphysical prestige from ethics and science also liberates them from the domination of metaphysics. In the case of science, it means that science has to make its way without the assurances of method but this allows creativity and ingenuity to come into play (Caputo, 1987). What this would entail for science is covered in more detail in the next section - The question of method in radical hermeneutic inquiry.

Caputo (1987) proposes an ethic within a radical hermeneutics. The ethical question to be addressed is how to dwell with one another? Specifically for this research how might nurses and breastfeeding mothers and babies dwell together? Caputo proposes an ethics of dissemination that strives to undercut the power structures that bear down upon us, and that serve to shore up binary oppositions such as male and female, rich and poor, privileged and unprivileged. For Caputo an ethics of dissemination is an "ethics of otherness, an ethics aimed at giving what is other as big a break as possible" (p. 260).

This break occurs by displacing the discriminatory oppositional schemes with open and nonexclusionary arrangements. It challenges the control and power centres in our culture by showing up the contingencies of their domination. It does this by keeping the conversation open, ensuring that no voices are excluded and restraining if possible the overbearing interests of the powerful. It challenges all rhetoric whose intent is to sustain domination. But it must do this without inflicting a "violence" of its own. In the words of Caputo (1997) "And it does this not by any show of strength of its own but by letting the system itself unravel, letting the play in the system loose" (p. 260).

It does this by showing up the difference, revealing the underside (see Smith, 2003 on p. 43), and highlighting rhetoric that sustains the prevailing order. It does this not to impose a new order, but simply to keep the conversation open and remain fresh to the complexities that arise.

The hallmarks of an ethics of dissemination are civility and fair play.

> If the Aristotelian polis demanded a phronesis, that is, the skill to apply the agreed upon paradigm, the modern mega-polis requires civility, which is a kind of meta-phronesis, which means the skill to cope with competing paradigms. Civility is the virtue of knowing how to like and live with the dissemination of ethos (Caputo, 1997, p 262).

An ethics of dissemination is at the same time an ethics of *Gelassenheit* which is the difficult art of letting-be. Letting be is the task of let all things be what and how they are. Miester Eckhart defined *Gelassenheit* as living "without why" (Caputo, 1987, p. 265). It means that we don't live on the basis of our expectations – we simply open ourselves up to the flux and the full difficulty of life. Letting-be resists the temptation to impose meaning as a way to gain the security of our conceptual foundations.

The Question of Method in a Radical Hermeneutic Inquiry

The question arises of how to proceed with inquiry, when one has taken a stance against methodologism and proceduralism? How to avoid making the inquiry subservient to the method? Caputo (1987) suggests that the first step in deconstruction of the method myth is "a strategy reversal, of standing the prevailing orthodoxy on its head" (p. 212). Caputo suggests that instead of method we need to develop "a deeper appreciation of *methodos, meta-odos*, which is "the way in which we pursue a matter (*Sache*)" (1987, p. 213).

From Heideggarian stance, method is the flexibility and responsiveness by which thinking is able to pursue the matter at hand (that is the matter of our interest). It is the intelligence to know how to move forward even though the path is not laid out in advance (Heidegger, 1954/1968). This flexibility and responsiveness comes from a kind of thinking that gathers and focuses our whole selves on what lies in front of us. As "the nature of reality and man is both hidden and revealed; it both appears and withdraws from view, not in turn but concomitantly" (Glenn Gray, 1968, p. xi). Only truly

involved, patient and disciplined thinking can come to know the hidden elements of truth. We must also be immersed in what we are thinking about so we can be responsive to what is being revealed. It is through this immersion that we can avoid our habitual ways of apprehending the world (Heidegger, 1954/1968).

> Search everywhere, question everything, entertain any hypothesis, and leave no stone unturned in the search of good science. Above, all do not be blinded and hamstrung but wooden maxims and methodological constraints when what the matter-*die Sache*-requires is plasticity, inventiveness and the ability to play along with the matter (Caputo, 1987, p. 212).

Thus in hermeneutic inquiry immersion, creativity, and flexibility constitute the die *Sache* – the way we pursue the matter we wish to understand more deeply. This playful approach can:

> …maximize the possibilities and keep the door open to results that have no come in yet; it will multiply the opportunities for what Derrida calls *l'inventions de l'autre,* the incomings of something we did not see coming.... Proceeding "*Sans voir, sans avoir, sans savior*," without seeing, savvy, or seizing hold of things (loosely translated), affirming a kind of structural blindness, keep us open to innumerable mutations and unforeseeable possibilities, to incalculable ways of being and knowing, doing and seeing, exposed to the potentialities of which we cannot presently conceive, to things improbable, and incomprehensible, unimaginable and unplannable (Caputo, 2000, p. 6)

The Cultivation of a Hermeneutic Imagination

Meaning is always arrived at referentially and relationally. That is meaning emerges in reference to particular contexts and within conversation with others or ourselves. Meaning is not preordained but produced in dialogue. In this research "hermeneutic conversations" (Gadamer, 1999, p. 388) occurred with nurses, with mothers and with text such as the breastfeeding discourses described earlier and written or artifact material from the Breastfeeding Centre.

Smith's (1999e) conceptualization of the hermeneutic imagination guided the analysis and writing process. The hermeneutic imagination is cultivated by paying close attention to language and how it is used. Since we live in language we need to be aware of its characteristics, its nuances, its moods and meaning and its history. Further we need to enhance our sense of life's interpretability by looking for what is between and beyond our words, actions, constructed spaces and our temporal awareness. The hermeneutic imagination is motivated by an all encompassing interest in the human condition and understanding the human story at this time and within its place in time. The hermeneutic imagination does not seek finality but rather uses its inherent creativity to create conceptualizations about the world to further collective understandings.

Further, the hermeneutic imagination strives to perturb deeper and new dialogue and thinking about the issues at hand. The creativity of the hermeneutic imagination can unfetter our thinking about issues and create a greater opening or clearing for truth to be revealed.

Finally, there is the acknowledgement that there is not final or full truth of things. There is not a searching for the resolution of multiple meanings, but rather understanding how these meanings have come to be. In sum to be animated by the hermeneutic imagination is to enter into the multiple play of meanings.

The researcher animated the hermeneutic imagination in this research in the following ways. The inquiry that began with the proposal continued with conversations and interactions with nurses, breastfeeding mothers and babies (Further details in next section of the paper). The conversations and interactions provided an opening to move deeper into the question, as it was through these real life situations that the research process expanded outward with the inclusion of lay and scholarly literature to examine what is disclosed and hidden about truth.

Doing interpretative work requires personal preparation of the researcher – a cultivation of the practice of listening deeply to the world and giving witness to what occurs (Smith, 2000). It requires careful and mindful attention to the moment, to everyday life. This practice requires a steadiness of attention, a returning to the situation over and over again alert for what is present and what is revealed.

The situations arising in the Breastfeeding centre and the reading of diverse texts on nursing, breastfeeding, politics, ethics, critical, historical perspectives, and wisdom traditions will provided opportunities to further interpretative understanding of truth as it is lived in nursing lives. The researcher entered into conversations with all of these entities, questioning and reflecting.

Writing and written work is a central expressive component of hermeneutic inquiry. The final written work that follows represents the outcome of the author's conversations but can best be thought of a part of a continuing conversation that will be expanded, discarded, clarified and deepened by those who read it.

All forms of writing are interpretative but some more easily move beyond the reduction and finitude and encourage the ongoing conversation to proceed. Different writing styles beyond the literal were used; metaphoric, narrative, poetic and satiric. These styles strive to express meaning that does not reside in attempts at literal representations. These imaginative forms of writing, as compared to attempts at rational representations, can more easily expand the realm of meanings that can be expressed and retain the multiple play of meanings that is the original difficulty of life. These forms of writing were used to more fully portray the ambiguity, uncertainty, paradox, and multidimensionality of life and truth as it is lived.

Guides Along the Pathway to Understanding

Research Question to Start the Conversation about Truth

How does a sense of truth arise in nurse and the breastfeeding mother-infant relationship?

First Steps on the Pathway to Understanding

Ethical Considerations

The researcher, as a student of the University of Alberta, an employee of OUC/ UBC Okanagan and conducting research at an Interior Health Authority facility, was required to seek Research Ethics Review Board approval three times. Approval was first granted from the University of Alberta HREB. Approval was then sought and approved

by Okanagan University College Review Board and finally at Interior Health authority. This process took seven months from July 2004 until February 2005.

The formal research for this project began with the researcher observing, tape recording and taking notes of the interactions between nurses and breastfeeding mothers at the Interior Health (IH) Breastfeeding Drop-in Centre in Kelowna. The Breastfeeding Drop-in Centre had been in operation for over two years. The Centre provides a no appointment, no referral required service that is open to breastfeeding mothers with children of any age for three mornings a week from nine a.m. to twelve noon. Public Health nurses with breastfeeding expertise provide the service. All nurses are ILCA (International Lactation Consultants Association) certified or have a completed a breastfeeding certificate course. There is also a volunteer who welcomes mothers, pulls files, weighs babies and assists with child minding if required. As well as the main drop-in centre nurse, there are up to two other nurses available for backup when the clinic is busy. Approval for the conduct of this research at the Centre was received from Jan Appleton, Health Services Area Manager, Central Region Interior Health Authority, and Diane McGillivary, Coordinator of Kelowna Breastfeeding Drop In Centre.

Participants in the research were the nurses and breastfeeding mothers present in the clinic. Nine nurses and twelve mothers participated in the observation component of the study. I initially met with the Breastfeeding Clinic nurses outside of clinic hours to explain the study and distribute information sheet (See Appendix A). The researcher answered the nurses' questions about the research and the nurses' potential involvement. Any nurses wishing to participate was asked to contact the researcher. The nurses who wished to participate in the clinic observations and/ or in further personal conversations signed the consent form with the researcher (See Appendix B).

The nurses working at the Breastfeeding Centre provided mothers attending the breastfeeding clinic with the information letter (See Appendix C) describing the participative observation component of the study. Mothers interested in participating signed the consent form with the nurse (See Appendix D). At the end of their visit to the Breastfeeding Centre, mothers who participated in this phase were given an information sheet describing the second component of the study, i.e. participating in a personal conversation with the researcher (See Appendix E). Mothers interested in this part of the

study contact the researcher directly and signed the consent form for a personal conversation with the researcher (See Appendix D).

Eight mothers who participated in participant observation at the Breastfeeding Centre consented to have personal conversations. These conversations were held in their homes (at the request of the participant) and lasted sixty minutes to one hundred minutes.

Four nurses, all of whom were lactation consultants and were the most consistent staff at the Centre, conducted sixty to ninety minute personal conversations with the researcher. All conversations were tape recorded and transcribed.

Protecting Confidentiality

Because the community of nurses who work at the Breastfeeding Centre is small, I have avoided providing descriptive details about the specific nurses to protect their anonymity. A distinction is made in the text specifying whether someone is a nurse or a nurse/lactation consultant.

Data Collection

> The ordinary events of out lives are always and already full of relations, the whole complex of human inheritance, full of voices and spooks and spirits and desires and tongues, and full of inheritances far beyond the human voice, rivers, and soil edges and coming of this solstice storm. Small events thus become potentially "fecund," presenting themselves as gateways or ways in to the luscious roil beneath the skin of familiarity. (Jardine, 2000, p. 106-07).

The research began by observing at the Breastfeeding Centre, watching ongoing series of fertile small events that unfolded everyday. It was by participating in these events and recording them on tape that my re-examination of the familiar world of nursing began.

Tape recording allowed me to attend to the denseness of the interactions that might otherwise have been lost. It also captured the background noises, the babies vocalizations, the nuances of pausing and repetition, and the vocal qualities of tone and emotion for later review and reflection. The lived world of the BREASTFEEDING CENTRE is often an auditorally complex and at times overwhelming place (crying babies, ringing phones, husbands, grandparents and friends)

Participative observation (Sandelowski, 2002) of the interaction of the nurses and breastfeeding mothers allowed me to be immersed in the flux and difficulty of the lives of

nurses and patients and served as a beginning source of data for the study. Participative observation provided a temporal as well as an embodied account of what occurred (Sandelowski, 2002). Participative observation rather than participant observation means the researcher will be experiencing the tactile sensations (holding babies), smells, sounds, emotional tensions and feelings that occur as well as what she can visibly see. I attended the Breastfeeding Centre as a participative observer for six weeks for the three mornings a week the Centre is open. In total sixteen days were spent at the Centre.

Notes and audio-recordings supplemented the observations when both the nurse and breastfeeding mother gave consent. As well examination of artifacts from the setting such as breast pumps, feeding tubes, information brochures and educational materials for both nurses and patients were examined. As they provided the media of the practice, they are a constituent component of lives of nurses and breastfeeding mothers. These technologies and texts are part the flux and shape both the nurses and patients experience. The observations, notes, audio recordings, and artifacts from the setting provided data but cannot be seen as providing "evidence" but rather as a material for critical examination to spur on the research.

CHAPTER FIVE

ENTERING THE BABYWISE WORLD OF BREASTFEEDING

Conversation at the Breastfeeding Drop In Centre

It's just after nine at the Breastfeeding Centre on a warm and sunny February morning. A twenty-something mother arrives carrying the ubiquitous car seat that identifies one as the caretaker of an infant. The mother's cheeks are bright from the chill of the outdoors. She bends and extracts a nine-month old baby from the car seat and takes off his jacket. He has a small perfectly oval face with soft brown hair growing close to his skull. He is a compact baby who quickly scans the room. He holds his body with the rigidity of a baby eager to launch himself towards all that beckons. His large blue eyes are rimmed with red. The volunteer approaches and addresses him directly. In a lilting voice she says – "Hi, how are you? So you came to see the nurse?" – his whole body acknowledges her attention and squirms. He momentarily responds with a half grin and then the effort becomes too much and he sinks back into his mother's arms. " Ahhhh" says the volunteer, a retired nurse, commiserating with his response – "You're not feeling yourself".

The lactation nurse approaches from her desk - "Hi! We haven't seen you for a while. How are things going?" The volunteer has asked the baby's name and age and has gone to pull the chart. The mom states " Not so great for the past month or so. He's been sick and not really eating well, and I don't think he's gaining." The nurse nods- "What's been happening?"

"Well first he had an ear infection, and I took him to the doctor and got antibiotics, and he seemed to get better but he still isn't himself – I think he has a cold now. He's having green stools and diarrhea, and he also seems to react to peaches and tomatoes – so I've stopped feeding him those". The nurse nods – "So a lot of things are going on. Let's weigh him and see where he's at."

Although this description is linear and one-dimensional at least two levels of interaction were at play in the actual setting - the conversation with the nurse- mother providing the melody, harmonized with the mother

responding to the baby and telling her story, nurse listening attentively to the mother, yet mindful and responsive to baby's activities. The history gathering is being woven together with a sensitive moment-to-moment attunement to the baby, mother's and nurse's actions

The nurse weighs the infant, talking further with the mother about the doctor's findings and recommendations and drawing forth the mother's observations and explanations for his sickness and diarrhea. The nurse explains what green stools are usually caused by and asks what happened when tomatoes and peaches were removed from his diet. The nurse then asks about the breastfeeding and how it was going. The mom said its going well but that he was easily distracted and sometimes it seemed like he didn't really want to nurse. "You know" the mother laughed – "so much for him to do and so little time". The nurse plots his weight on his height and weight growth graph – he had actually lost weight and dropped below the 25th percentile for weight since he had last seen a nurse. The graph showed that he had always been around the 25th percentile in weight, occasionally dropping below in his first four months of life. He was an active baby that was more interested in the world around him than eating.

The nurse asks the mom to describe a typical day of the baby's feeding and activity. The mom outlines a detailed account of his daily routine and food activity. She ended by saying he typically ate something about eight p.m. and then didn't eat again until around 6 a.m. While asking questions and listening to mother's responses, the nurse was simultaneously responding to the baby, smiling at him and commenting on his vocalizations and movements. Together the nurse and mom calculated about how much food and milk he was taking during the day. For his weight, although eating sufficient solid food he was taking slightly less milk that was recommended for optimal growth. The nurse asked, " Does he ever wake up during the night?"

The mom said "Yes he usually wakes up at 1 or 2 times during the night, although when he's been sick he's can wake up more often."

"What do you do when he wakes up at those times?

"Well usually I just change him and hold for a bit until he settles. - You know, I'm trying to get him sleeping through the night. Because at nine months he should be doing that, right? I know all my friends' babies do and I've been wondering if I need a schedule to help him do that? and I've kind of been trying to schedule him – that's why I haven't been feeding him during the night. I'm also worried about overfeeding him, if I nurse him when he's upset – since he's been sick he'd be nursing almost all the time."

The nurse pauses before replying "Well I'm thinking that you actually describe sounds like a schedule – he gets up certain time, has his breakfast, plays, has a nap – has lunch – so there is routine. And we know when we are sick those routines just disappear. Are you thinking of something more scheduled than that?

The mom hesitates – " Well you know, I'd just like him to sleep through the night. I worry about him becoming one of those babies – who never learn how to sleep through and I don't think that's good for him"

The nurse reflects on the mom's comments for a moment and then continues " He's been sick, and sickness always mean our usual patterns get disrupted, so perhaps a more rigid schedule isn't the best thing at this time.... What I would try – is to nurse him when he wakes up at night – it will probably just be a short feed but it would bring the number of times he nursed in a day closer to what we'd expect for a baby his age, I'd bet it might make the difference in his weight at this time. What do you think?"

The mom agreed that she would try nursing during the night when he awoke. They agreed the baby would be checked by his physician to rule out any health problems and that the mom and baby would return in the Breastfeeding Centre in a week to monitor his weight.

As I listened to the interaction, I wondered - if the baby was awake, and the mom was awake – what would cause her not to feed? As a nurse with a background in midwifery and lactation, I'm aware the baby who sleeps through the night is one of the mythical and highly coveted "Good Babies". It's human nature to want to be able to sleep through the night and for parents to long for that pre-baby time when you could sleep for as long as you wanted. Yet this mother was awake and up changing his diaper– so her

sleep had already been disrupted. Why not feed? Especially if he hadn't been eating well and she was concerned with him not gaining or losing weight.

As a lactation consultant, I'm sensitized to people wanting the 'perfect solution' schedule that would remove the uncertainty and unpredictability from breastfeeding. I wondered if this is what is happening here - that she's trying to impose the 'one size fits all' schedule on a sick, easily distracted and seemingly easily pacified child. I'm aware of babies who are labeled "happy to starve", a term that carries only ironic associations to true happiness. "Happy to starve" babies are ones who learn to quit fussing and crying when their cues for hunger are ignored by their caregivers. They become passive and seemingly "happy to starve", quickly acquiescing to a world where their basic needs are not addressed. Was this a "happy to starve" type of baby?

The mother's question about overfeeding showed concern with "correctly" managing food and other dimensions of his life. There seemed to be a focus on what "should" be happening rather than what the child and mother needed from each other at this particular time. The mother was certainly well intentioned, caring and attentive to her child. Her reaction to his nighttime wakefulness seemed incongruent with the attunement to his needs that she demonstrated in her moment-to-moment interactions with him. What was happening to disrupt the apparent maternal-child synchrony I observed? What was drawing her away from being responsive to his need for more breastfeeding?

After the mother and her son left, I asked the nurse "What do you think is going on with that mom and baby?

The nurse considered for a moment and said, "I think it's Babywise."

"Babywise?"

"It's a book that's promoted by some of the churches in town. It focuses on getting the baby to sleep through the night. The moms are also told that Public Health doesn't like it – so mothers are often reluctant to mention to us that they are trying it."

Initial Reflection

Motherhood and breastfeeding are highly contested spaces. The introductory discussion of historical, scientific/biological, political, economic, gender and social discourses in Chapter Four illustrate some of the multiple and competing perspectives occupying that space. For the most part discourses such as these appear distant and

removed from actual mothering and the material circumstances that determine the choices mothers make in their day-to-day lives with their babies. *Babywise* can be thought of as emblematic of such discourses and provides a contrast to the relationship of mothers and nurses.

Unlike discourses that theorize, postulate and impose without understanding of the individual or the particular, nursing practice is grounded in the immediate material circumstances of mothers. The day-to-day lives and present concerns of mothers are foundational to the practice of nursing. In the opening vignette the nurse, knowledgeable in the beliefs, myths and misperceptions surrounding breastfeeding and parenting, grounded her practice and questions in the mother's experience. She asks "What's been happening?" "What's his routine?" "Does he wake up at night?" She begins with the details of the mother's concrete experience of living with her child at this time. She asks these questions free of assuming that she knows what has been happening and what the mother is experiencing. The nurse asks her questions to better know this mother and better understand what information the mother is seeking. She is working together with the mother to turn over and reveal the various pieces of the puzzle. She and the mother are constructing a panoramic view of the current life of this mother and infant.

The nurse's feedback is linked directly to mother's concerns –"Why are his stools green? What should I do about food that he might be allergic to? Does he need a schedule?" The information she gives is rooted in the issues raised by this particular mother at this particular time. She connects her nursing knowledge and experience to this woman's daily experience with her baby. Her answers are factual, but non-directive in their delivery. They are answers offered as information not prescriptions. She does not dismiss a schedule as inappropriate but offers instead a broader definition of schedule in light of the baby's illness. Her words indicate it is possible to "soften" the categories or criteria inherent in the mother's expectations and still be a good parent. Slowly but surely the conversation between the nurse and mother leads to a broadened view of what might be possible and workable. While the nurse is concerned with weight loss in the baby, her actions generate neither judgment nor fear. The atmosphere is straightforward and calm. The nurse's suggestions are put forth as possibilities for action and impart trust in the mother and optimism that things will improve. The message to the mother is to rely on

the authority of her own experience with her baby. It is clear that the nurse is committed to the welfare of both the mother and the infant. As the mother leaves, it is apparent that worry has been lifted from her.

To Name or Not to Name

My initial thoughts on hearing the word Babywise and the nurse's concern that it had to be approached very carefully, was that Babywise was like the proverbial elephant in the living room that no family member wants to acknowledge, lest naming it disrupt the status quo. The mothers know about Babywise, the nurses know about Babywise – yet it is not being mentioned or named. Was this a denial of a controversial issue? Avoidance of a problem or conflict?

Obviously there are worlds of meaning for mothers and nurses encapsulated in the name Babywise. The following very simplified summary of some the meanings in Babywise demonstrates the division or separation of understanding and meaning the term held for nurses and mothers. For some mothers, Babywise was a church and peer sanctioned resource that promised them some sleep at night and a well behaved happy child. To the nurses it was an unscientific and potentially unsafe anti-breastfeeding approach to childcare that because of it religious sanction made it difficult to challenge. The nurses were well aware of the dissonant meanings Babywise held and were reluctant to emphasize the differing perspectives.

The question becomes how best to bridge the chasm between the two perspectives. There are a number of alternatives – naming or not naming Babywise. To name something is to bring forth into the present and into the "now" those worlds of meaning. Bringing something into the now can call forth unintended reactions.

In postmodern times, naming is seen as a powerful or empowering activity, such as naming harassment or discrimination. It can make a personal experience into a political and shared experience, and be cathartic for those who break their silence to name. Yet in some instances to name something can also give it more power. In the Harry Potter stories, the evil villain was referred to as "he who could not be named". For the residents of Hogwarts, to name the villain was to bring evil he represented into the moment and into the world. Unlike family denial of and unwillingness to name potentially divisive issues (the proverbial elephant in the living room), the nurse's

decision not to name or evoke Babywise effectively served to divest Babywise of unearned power.

To name comes from the Old English 'neim', meaning a particular designation (Oxford Etymology Dictionary). To designate is to specify and to exclude that which does not fit. In our Euro-western culture naming is used to classify and clarify. Further, we use naming to differentiate and distinguish. Naming creates demarcations. It becomes difficult when things are named to overcome those demarcations. That is, to bring those things together again to see they overlap, associate and connect. Thus, naming can create unnecessary polarities. Perhaps the name Babywise and what it *designates* for the mother and for the nurse is so particular, so specific and so individual for each participant, it becomes a word that is divisive rather than bridging. Therefore it is better that it not be named, for to name it could potentially disrupt the commonality and partnership that had developed between the mother and nurse. To name it could bring closure to the conversation and the interaction.

Naming fixes meaning. For example in Genesis the naming of animals has been linked with fixing of their characters. In this instance the name Babywise can fix or lock the mother and nurse in divisive polarities that could take vitality from the story the mother was telling and not allow the nurse to hear the message as it was delivered. The nurse's decision not to explicitly name Babywise, allowed the mother's own story to come forth and evolve.

Yet Babywise exists and named or not, it can be a powerful and persuasive discourse in the world of new parents. As the earlier vignette showed, Babywise is a discourse that can take mothers away from their connection to their children and seemingly cause them to act contrary to their common sense. The Babywise discourse and the excessive certitude and fundamentalist rigor of its' ideology is the antithesis of the world of real mothers and real caregivers. Because its assumptions and practices are so potentially damaging, the Babywise message needs to be named and brought into the open. The world of Babywise stands in stark contrast of the practice of nurses at the Breastfeeding Centre. It is my intent to name Babywise here and expose the dominating effects and dangers of the discourse. (I acknowledge here Foucault's notion that everything is dangerous (Foucault, 1980) and his statement that we all participate in

regimes of truth. Therefore I also acknowledge the need to examine the danger of nursing discourses as well. This will be done later in the document.) Examination of the Babywise discourse, its practices and its inherent meaning provides an opening and means to reveal the contrasting richness of nursing practice. (I am aware that I'm creating a dualism here. It hardly seems like a good idea to use a dualism when trying to talk about overcoming or moving beyond dualities. So although I'm aware of the discourse and its dangers I'm also caught within them, their strategies and techniques. It is impossible to step outside them or be uninfluenced by them.)

The word Babywise is imbued with much meaning and points to much that lies beyond it. The following questions guided my investigation and reflections on Babywise and its creator(s). What is Babywise? What are the inherent features of Babywise and its underlying assumptions? What discourses surface when Babywise is examined? As a textual and cultural artifact, what can examining and questioning the text of Babywise show us about the context that mothers and nurses inhabit? Specifically, what does Babywise point to in our understanding of parenting relationships, of nurse-patient relationships, of human relationships? What can Babywise tells us about Breastfeeding and nurse-patient relationships? Through the examination and questioning of Babywise, what is brought forth that inheres in the practice of nurses with new breastfeeding mothers?

The remainder of the chapter is divided into two sections that address (albeit in a preliminary manner) the above questions. The first section is a description of the basic tenets of Babywise and an overview of controversy that the publication of these books has evoked. The second section is an in-depth examination of the discourses and cultural space that the Babywise phenomena creates, replicates and dwells in.

The Babywise World of Parenting and Breastfeeding

My experience in the Babywise world was like dropping down the rabbithole in Alice in Wonderland. The commonly held assumptions about parents and children no longer seem to apply. For a health professional, or any person with an understanding of opinions versus evidence, feelings versus facts, and weighing and determining the relevancy, representativeness and adequacy of arguments, the Babywise universe is a topsy turvey, chaotic, bewildering and at times nonsensical place. Science and biblical scripture are mangled, twisted and represented to support the Babywise philosophy and

protocols. Whenever I was immersed in the Babywise dictates and critiques, I was confused, aghast and saddened. It was a world alien to the best of nursing practice and mothering.

My drop down the Babywise rabbit hole began with a handout that the Breastfeeding Centre nurses share with mothers about the book *Babywise*. The handout from the International Lactation Consultants Association (ILCA) – the licensing body for lactation consultants around the world – was reprinted from the American Academy of Pediatrics (AAP) newsletter and was entitled "Pediatricians be advised: 'Babywise' potentially harmful" (Aney, 1998). In the article, Aney critiqued the 1995 edition of the book for its Parent Directed Feeding (PDF) program which recommends among other things, feeding intervals of three to three and half hours beginning at birth and the elimination of nighttime feeds at eight weeks. These recommendations are in direct contradiction of demand or cue feeding as endorsed by the AAP, the World Health Organization (WHO), ILCA, and La Leche League (LLL). The Parent Directed Feeding program has been linked with failure to thrive, poor weight gain, dehydration and breast milk insufficiency. The concerns were startling. Scientific evidence had been growing for the benefits of demand (cue) feeding for the previous two decades. Why would something so lacking in credibility be so popular? Surely the latest editions of the book had been updated to bring the advice into line with current knowledge.

Eager to buy the book and see for myself what created such controversy and to find out if the most recent copy of the book was still giving such blatantly bad and inaccurate information to new parents, I went online to order. However the book was backordered (because of popularity?) and I had to wait almost 6 months to get a personal copy. While waiting for the book I began to search for information on Babywise and its author. There was no shortage of widely divergent opinions about Gary Ezzo and his books. What follows is an overview of what I found.

On Becoming Babywise is one in a series of top selling and highly controversial childcare guides for secular use first published in 1993. *Babywise* is the secular version of conservative Christian parenting materials known throughout the 1990s as *Growing Kids God's Way (GKGW)* and *Preparation for Parenting*. These resources were renamed *Along the Infant /Toddler/Virtuous/Middle Years/Adolescent Years Way* in 2002

(www.ezzo.info/Timeline/timeline2.htm.). The secular and religious books are basically the same, with all biblical and theological references removed from the secular *Babywise* versions. *Babywise* is marketed to Christian health care providers as a resource to give to new parents. While the activist evangelical agenda is clear in the openly religious material, parents who buy or are given the seemingly mainstream *Babywise* books have no way of knowing the books are based on the unique biblical interpretations of its primary author Gary Ezzo (Granju, 1998, p. 43).

Ezzo, a former pastor with no undergraduate training and a Masters of Arts in Ministry earned primarily for life experience, and his wife Ann Marie [8] are credited as authors of the Christian books. The secular copies of the book are endorsed/co-authored[9] by Robert Bucknam, a pediatrician. Ezzo is Executive Director of the for profit organization *Growing Families International (GFI)*. GFI was originally formed as a nonprofit ministry to assist new parents in 1987, with five other couples from Ezzo's church. In 1989 the nonprofit corporation was dissolved and GFI became a for profit corporation, with Dirk Williams as president. Williams and his wife severed ties with GFI in 1993 due to concerns about integrity and the content of the program (http://www.ezzo.info/Timeline.timeline1.htm).

Religious Critique

Christianity Today (Giles, 1993) published the first national article voicing concerns about *GKGW* and reports of infants with low weight gain and emotional withdrawal. By 1994, one year after the publication of the first secular edition, another of the founding GFI couples had severed ties with Ezzo citing concerns with integrity and the content and impact of the program (Abel & Abel, 1996). Multnomah, a Christian publishing company, published the second edition of Babywise in 1995. In October

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[8] Although described on the GFI website as a registered nurse, the only record that can be found of her employment as a nurse is for a few years in the early 1970s (http://www.ezzo.info/Timeline/timeline1.htm). It is unclear what area of acute care she worked in at that time and whether she had any experience in maternal-child care.

[9] Bucknam's actual role in the writing of these books is unclear. Although Bucknam was listed as co-author on first version of Babywise (1993), this version was virtually identical (only the explicit religious language was removed) to the religious version published at the same time that was only authored by Ezzo and his wife Anne Marie. At the time of the release of the 1993 edition, Bucknam was young, inexperienced doctor in the midst of a pediatric residency (http://www.ezzo.info/Timeline/timeline1.htm).

2001, after an eight-month saga of canceling and then reversing the cancellation of Ezzo publishing contract, Multnomah announced their "mutual" decision to return publishing rights to these books to Ezzo. The books are now self-published by Ezzo's company *Parentwise Solutions.*

In 1995, Ezzo withdrew from his church in California after pastoral staff demanded he make changes in the GKGW material to address the concerns being raised. In 1997, the church issued a public statement to explain why the church was no longer affiliated with Gary Ezzo and GFI and why they no longer used or endorsed the GFI materials. In 2000 Ezzo was excommunicated from his next church, Living Hope Evangelical Fellowship, also in California. The pastor of this church and two of its elders had previously worked for Ezzo and GFI. This was the third church that Ezzo had left. In the early 1980's he had been asked to step down from a leadership position in another church amid complaints of authoritarianism and divisiveness. In 2002 the Ezzos moved from California to South Carolina and joined Seaworth church. This church offers the all the GKGW parenting programs (http://www.ezzo.info/Timeline/timeline.htm).

In 1996 sufficient concern was raised about *GKGW* parenting programs, that the Child Abuse Council of Orange County appointed a religious task force to evaluate the material. The criteria for good parenting program established by the task force was as follows: 1) builds child's self-esteem and respect, 2) fosters parental discernment, 3) considers individual temperament, 4) developmentally and age appropriate, 5) balances loving guidance and discipline. The Task Force determined that the majority of the GKGW programs aimed at all ages of children failed to meet any of these criteria (CAPCOC, 1996, p. 3).

The same year *World* magazine published on article entitled *The Ezzos Know Best: Controversial Parenting Curriculum Sweeping the Church.* This article described both the praises and concerns that various people and organizations had raised regarding GFI. Ezzo reacted by calling for the resignation of Ron Maynard, the author. Ezzo then fabricated an interview with Maynard and placed it on the GFI website, in order to discredit Maynard. Ezzo further demanded Maynard's church take disciplinary action against him.

Other reputable Christian publications (Christian Research Journal and Christianity Today) have described the behavior of the GFI as "cultic" (Terner, & Miller, 1998) and question Ezzo's qualifications and character to teach parenting (Terner, 2000). Because the essential doctrines of the Christian faith as taught by Ezzo are considered orthodox, Terner and Miller were unwilling to label GFI a cult. However there are enough areas of concern to earn the label "cultic". Specifically, five ways are listed in which the behavior of GFI parallels a cult. They are: 1) Scripture twisting and de facto assertion of extrabiblical revelation to support their perspective on parenting; 2) Authoritarianism where individual interpretation is not allowed and where Ezzo is not accountable to any outside group; 3) Exclusivism where the Ezzo perspective is elevated to gospel revelation and where Christians holding different views are viewed and treated as sub-Christian; 4) Isolationism where those involved in GFI teachings are shielded from other views and teachings ; 5) Physical and emotional endangerment where some babies are left to cry for hours and some newborns are underfed and underdeveloped (Terner, & Miller, 1998, p. 3).

Ezzo's recommendations have also been criticized by a number of Christian organizations. Joseph McCrae, speaking on behalf of Dr. Dobson of Focus on the Family (FOTF), a Christian not for profit organization directed at the preservation of the traditional American family, acknowledged their organization has heard positive testimonial reports of the helpfulness of Ezzo's materials (McCrae, 2004). He also noted that despite these positive reports their organization had a number of concerns and reservations about Ezzo's work. The three major concerns are 1) inappropriate use of scriptures, 2) inappropriate use of scientific literature to support Ezzo's particular approach to parenting and 3) failure to respond appropriately when concerns were raised about use of scriptures and the scientific literature. They summarize by naming Ezzo philosophy of childreading as far to rigid and "exclusivistic".

What FOTF found most troubling was the Ezzo's response to these concerns raised by others. Rather that addressing the concerns directly, Ezzo attacked the critics and labeled the questioners "anti-Christian". They also note that a number of respected Christian publications have documented character and accountability issues that have arisen between Ezzo and several reputable churches.

Secular Critique

The Christian and secular books had long concerned health practitioners and parenting experts. These experts included Dr. T. Barry Brazelton, British parenting expert Penelope Leach, Dr. Kathleen Auerbach, former president of the International Lactation Consultants Association (ILCA), Kathleen Huggins, author [10] and Dr. Matthew Aney, a Christian pediatrician and member of the American Academy of Pediatrics (AAP). In April 1998, a hundred doctors, lactation specialists and childcare professionals sent a letter to the AAP contending that a number of Ezzo's statements were unsubstantiated, false, and potentially dangerous. Although not naming Ezzo specifically, the AAP responded by issuing a Media Alert reaffirming its position that scheduled feedings may put babies at risk for poor weight gain and dehydration (BabyCentre, 2005). Ezzo then responded in a BBC radio interview "Well, first of all, our advice on feeding babies is identical to the American Academy of Pediatrics." (www.ezzo.info). This occurred after the AAP passed resolutions stating that Ezzo's PDF program "outlines a feeding schedule inconsistent with AAP recommendations" (Terner, 2000, p. p.5)

By 1999, the secular media including the Washington Post and Ladies Home Journal had published articles documenting case studies of infants who were failure to thrive as a result of following Ezzo's edicts.

Critiques of the author of a book that is so popular and appears to carry so much weight with parents are disturbing. Yet, just as the nurse at the Breastfeeding Centre said, "parents know we don't like it", other health professionals have voiced similar concerns. The Ezzos forbid debate in their parenting classes and told parents not to initiate conversations about the curriculum outside of class. Some professionals fear these rigid rules may keep parents from talking about the Ezzo program with their own doctors (Giles, 1993). Dr. Michel Aney (1998) noted that parents are "hesitant to tell their physicians about the schedule, making it difficult to pinpoint the cause of weight gain problems. Many elected to supplement or wean to formula rather than continue

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[10] Incredibly, although both Auberach's book *Breastfeeding and Human Lactation* and Huggin's book *The Breastfeeding Mother's Companion* warn against Parent Directed Feeding, in the 1998 edition of Babywise, Ezzo cites their work as being supportive (Auerbach, 1998; Donohue-Carey, 1999; Granju, 1998).

breastfeeding at the expense of the schedule. The parents' commitment can be particularly strong when they are using the program for religious reasons, even though numerous leaders within the same religious communities have publicly expressed concerns." (p. 3-4). Aney encouraged health practitioners to undertake careful histories to determine what is actually happening with the infant feeding. Health care professionals approach schedule feeding very diplomatically – never mentioning Babywise unless the parent specifically does. At a larger public health level how do health professionals ensure parents have the full story and know the associated dangers if Babywise is never mentioned? As shown in the opening vignette, it is a difficult topic to broach when trying to build a trusting relationship with a breastfeeding mother.

Questioning the Horizon of the Babywise Literature

As I investigated Babywise and its primary author – I became increasingly uneasy. Who is this man? What is his intent? It is evident that Ezzo's words are powerful shapers of the thoughts and actions of many parents. Most of the critiques focused on the religious versions of the book *Growing Kids God's Way (GKGW)*[11] (in 2002 renamed *Let the Children Come)* and/or the 1998 *Babywise* edition. Any thoughts I might have had that current (2001) secular Babywise would address the earlier concerns and the author(s) had learned from criticisms were soon put to rest. If anything they had become more artful in their misrepresentations. Ezzo and Bucknam appear to be stuck in a repeated representation of a cramped and limited ideology.

When I received my personal copy of Babywise, I initially tried to read it from the perspective of an inexperienced new mother. I could see how someone anxious about how to handle the new reality and changes a baby brings to a family could find the book appealing. Ezzo's work appears to address widely held childrearing goals. We all want to be responsible parents and want our children to be happy, pleasant and well adjusted. We want to have a peaceful home life without stress and exhaustion. "People follow Ezzo because they want to believe they can have both a new baby and a good night's sleep (Aney as cited in Webb, 2000b, p. 20).

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[11] Although the latest edition has been renamed I use GKGW to refer generically to all Christian publications past and present.

Parents are offered what to be many would be a seemingly rational plan. Much of the attractiveness of the program derives from the guarantee that if they follow the Babywise Parent Directed Feeding (PDF) precepts they will be able to "control" their children (Auerbach, 1998).

Control is the great myth of our technological world. It is the myth that humans have the power to shape and meld the future to whatever we desire or imagine. It is the fantasy that we can somehow direct or limit change to only those things that we want and wish for. All dimensions of our culture feed into this myth – our homes, our cars, our planning efforts at work - even health care with its illusory promise of cure leads us to believe that we can be in control. We attempt to compel a situation or relationship to be the way we want it out of fear that we won't be considered a good parent or a good religious person. What gets lost in these futile attempts is the reality that most of what occurs in life is well beyond our ability to dominate or direct. The results of our attempts to control our children can ironically result instead in the out of control or depressed teenager.

The myth of control persists despite daily information that should cause one to question. On a daily basis we are confronted on both an individual and global level with that we cannot control or direct the course of. The weather rains on our picnics, melts our ski trails and parches our soil. Despite daily vivid reminders of our powerlessness to affect our destiny, we cling to the idea that we can and should be in control and our inevitable failure to be in control is the cause of great personal and group suffering. The world is fluxing and changing whether we know it or not, whether we like it or not. We are called to respond to this flux and change. What are the consequences of denying the symbiotic reciprocal nature of our relationships?

The attempt to control our children and our relationships with them will be discussed in more depth later in this chapter.

I next read the *Babywise* from my perspective as health professional and an academic and became further appalled. Although it appears that the most dangerous[12]

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[12] In the previous editions of the secular and Christian books, Ezzo recommended that children be put to sleep on their stomach in direct contradiction to the research and AAP statement recommending back-sleeping for children. The research has consistently shown

recommendations have been removed, gross misrepresentations of other parenting styles and the inclusion of pseudo-science to support Ezzo's beliefs set the tone for the book.

Questioning the Babywise Narrative Representations

Ezzo narrates two family scenarios to contrast his superior parenting method with the obviously undesirable alternative. His representations are telling. The 2001 edition begins by comparing two children, Chelsea and Marisa. As in earlier editions of the book poor Marisa doesn't have a chance. In 1998, her problems resulted from her mother demand feeding her. Statements such as " The erratic nature of the demand-feed (or free feed) theory negatively impacts Marisa's metabolism' (Ezzo & Bucknam, 1998, p. p. 43) are used to explain the cause of Marisa's distress. They carry on "… lack of regularity sends a negative signal to the baby's body, creating metabolic confusion that negatively affects his or her hunger, digestive and sleep/wake cycles." None of these statements has a physiological or medical basis. In 2001 edition, these particular false, yet seemingly 'medically authoritative' statements have been removed. Whether the vociferous challenges by health professionals asking for support these statements regarding metabolic confusion secondary to demand feeding (Barger, 1998) affected this change is unclear. These statements have however been replaced with other questionable 'medically authoritative' statements in the latest edition.

While demand feeding is no longer the primary evil causing Marisa's problems, other demons remain for the PDF forces to vanquish. In 2001, it is the

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that this practice reduces Sudden Infant Death Syndrome (SIDS) by 30-50% (McKenna & Mosko, 1993; McKenna & McDade, 2005; Sears, 1995; Skadberg, Morild, & Markestad, 1998). Although the reasons why back-sleeping reduces SIDS not fully understood, the magnitude of the finding led to the AAP and public health departments to institute policy statements and back-sleeping promotional campaigns. Yet in the earlier editions of the book, Ezzo described this research as inconclusive and states the infant may aspirate vomit if they sleep on their back. In the wake of harsh criticism, the 2001 edition cites the AAP recommendation. However it is followed by a discussion of whether back-sleeping is a primary or secondary factor in the prevention of SIDS. These comments serve to lessen the overall impact of the AAP recommendation. Finally parents are referred to their physician to address their questions about positioning. Although the authors appear to have made adjustments to their previous stance because of liability concerns, Babywise on the whole still gives lukewarm support to what could be a lifesaving practice.

demon of child-centred parenting (CCP) that poor baby Marisa falls victim to. In the past Ezzo has described CCP as "Satan's tool to destroy the family" (CAPCOC, 1996). The authors' demonization of child-centred or attachment parenting is demonstrated in the following excerpt.

> Marisa's parents have adopted the child-centred approach. As a result, Marisa will never have to wait for anything. If she wants something, it is given to her on demand. Baby-sitters? They make Marissa uneasy. So an evening out alone is simply not an option. Either her parents will take her everywhere they go, or they will miss a function due to Marissa's inability to take part. As for eating, if Marissa, suddenly rejects her bananas, she'll be offered a variety of options until her particular preference is revealed. The mom will then stock the shelves full of Marisa's delight, only to learn days later that the child's pleasure is back to bananas. Welcome to the circus.
>
> Sadly Marisa's parents are not aware of the disabling impact their attitude has on their daughter. Instead of building Marisa into a self-assured adult they are fostering the emotionally crippling attitude of *me-ism* (Ezzo & Bucknam, 2001a, p. p. 23).

This excerpt clearly shows how child-centred parenting (CCP) is used to highlight the superiority of PDF and all its associated dogma. The Babywise authors are known for redefining terms and misrepresenting ideas and theories to suit their own purposes. "They discredit a parenting concept by defining it as an extreme that is then decried as invalid and/or harmful" (Donohue-Carey, 1999, p. p. 23). In all versions of the book, accepted methods of child rearing supported by the majority of professional opinion are misrepresented and disparaged in order to champion PDF. In the early editions of the book it was demand feeding that created difficult, bratty children who lacked respect for others and in 2001 the primary parenting concept discredited is Child Centred Parenting.

Notice the overblown language and inflexible, inflammatory terms – "Marissa will never have to wait for anything". In one sentence, Marisa begins to take shape as a unrealistically demanding and impatient child. The word "never" propels our thoughts into the future and we can see Marisa as an out of control adolescent that wrecks havoc in the lives of those around her.

In the next sentence, the demon of the 1998 edition raises it head in a disguised but never the less recognizable form. " If she wants something, it is given to her on demand". Although demand feeding is not mentioned until later, the negative associations with the word demand are beginning to be shaped for the reader. Here, a small infant, who in actuality is tremendously vulnerable and dependent on those around her and who has limited means to ask for what she needs, is characterized as being demanding - that is having unrealistic wants and desires. The authors infer that infants seek to manipulate their parents to their own will (Auerbach, 1998). Further this vulnerable child is portrayed as wielding tremendous power in this situation. This statement portrays issues of control and power that seem an anathema to a normal loving parent-infant relationship. Parenthood begins to be envisioned as a struggle or a battle that someone must win.

Next the specter of parental entrapment is raised. "Babysitters? They make Marisa uneasy." This statement equates one characteristic of an individual child's temperament with her whole personhood. This one characteristic is then used to dismiss a whole approach to parenting. In the next sentence "Either her parents will take her everywhere they go, or they will miss a function…". The reader begins to see their baby tied to them like an anchor, weighing them down and drawing them back or at minimum not letting them move forward. The only vision of parenthood that is offered is that they as parents will be confined to their home without possibility of reprieve or escape. These statements present black and white, non-nuanced perspectives of parenthood.

Those familiar with child development know that separation anxiety is a normal developmental state that occurs around 8 to 9 months, at 15 to 18 months and sometimes around 2 years and again around 5 years (Webb, 2000b). Instead of being interpreted as a sign of cognitive growth for Marisa and positive attachment to her parents, readers of Babywise are left with the impression that "uneasiness" is problematic behavior , an infant personality or parenting deficit.

The statement suggests that there is no way to assist an uneasy child to become more comfortable with others and the only way of dealing with the child's natural tendency is to become a martyr. It further suggests that child-centred parents would not attempt to assist their child to become more comfortable with strangers. In actuality,

most child-centred parents would be very aware of what caused their child's 'uneasiness' and would work with the phenomenon, rather than become overwhelmed by the behavior as the *Babywise* description of Marisa suggests.

The description of Marisa's eating behavior again portrays the parent at the mercy of the child and reinforces the battle and conflict model of parenting. In this demonized child-centred portrayal of parenting, there is always a battle and the parent always loses to the demanding child. A child changing their food preferences is not presented as a normal occurrence, but rather as something that must be squashed and dealt with in a forceful manner lest one's own life becomes a circus.

This lack of understanding or disdain for commonly known thought about children's developmental stages and the behaviors that accompany them is further illustrated *In Becoming Babywise 2 (5-15 months)* (2001b). In this book it is recommended that babies be trained through a series of reprimands that progress from verbal sanction, to swatting, to isolation for touching their food. These reprimands are counter to every thing we know about children's learning. "If you teach a child a new skill when the child is ready intellectually, physically and emotionally ready then the teaching will be almost effortless. However, if you try to teach the skill before he or she is ready it will be like beating your head against the wall " (Wright as cited in Webb, 2000a, p. p. 19)

Ignoring the developmentally necessary and appropriate nature of children's tendency to interact tactilely with its physical world and to decline eating a particular food, creates a paralyzing environment for a child. Whether or not one agrees with Piaget's stages of child development, it is evident young children are sensori-motor beings. Infants are born with basic motor reflexes, exercising and coordinating these reflexes during the first two years of life, the infant develops intentionality and an understanding of object permanence. Cognitive growth in infants occurs when babies interact with interesting stimuli. To expect passive acceptance of every adult action will result in an under stimulated baby with an under stimulated brain. This patronizing description of Marisa's eating behaviour demonstrates Babywise authors' ignorance of normal childhood development and disdain for individuality and variability.

The authors further demonstrate their ignorance of or disregard for normal child development thought by labeling *me-ism* in an infant as emotionally crippling. Infants are by definition self-centred and learning to give to others is a process that is learned over time – not in infancy. Most childcare experts agree that what emotionally cripples infants is not having their needs met (Goldberg, 2000; Woodward, Fergusson, & Belsky, 2000). Failure to address an infant's needs for attachment makes becoming less self-focused and narcissistic a more difficult task as the infant ages. Francis (1998), a doctorally prepared counseling psychologist, questions "Is the need to root out age-appropriate narcissism in the child actually due to projection of an unheathy narcissism in the parent? (p. 30). I would add, is it reflective of an unhealthy narcissim in Ezzo?

Throughout this description of Marisa, the authors conflate child-centred parenting with excessive permissiveness and the outcome of selfish children. Sentence by sentence the authors create and massage the specter of an unlikable and undesirable potential child for new parents. Once they had created the monster child, they then fabricate what is from their perspective a model baby. Compare the selfish baby Marisa with baby Chelsea:

> Across town, Chelsea's mom and dad are working to integrate Chelsea into the existing family structure. She is a welcome member of the family learning from the start that giving is equally as important as receiving. What a joy she is to have around. Everyone comments on her peace and joy. And why not? Chelsea understands that she is a member of the family team. She already has a sense of the belonging and purpose for her life. This *we-ism* approach teaches Chelsea to foster close and loving relationships which endure the test of time(Ezzo & Bucknam, 2001a, p. p. 24).

Compared to the uneasy and demanding Marisa who wouldn't want to have a peaceful and joy to be around child like Chelsea. Yet a deeper analysis of Chelsea's life reveals a disturbing picture. Stressing that Chelsea's parents are attempting to integrate Chelsea into the family structure implies this would not be something that Marisa's parents are doing or that all parents attempt to do. The addition of the word existing to this scenario adds a further dimension to normal adaptation to parenthood. The "existing family structure' implies that no change is necessary in Chelsea's house - that the current

situation even with the inclusion of a baby need not change markedly change. It is implied that the "right" approach to child rearing alone can maintain the status quo of the pre-baby marital dyad and further that maintenance of the status quo would be a desirable state for new parents. This contrary to our common sense knowledge that in any situation that the addition of a new individual to the mix changes the dynamics and no amount of will or control can prevent those changes. It is also contrary to our common sense understanding that parental responsiveness and adaptation to the changes a new baby brings is a mark of parental maturity and responsibility.

The authors however imply that no change is required from the parents and no adaptation to the new member is a good thing for all parties involved. Instead Chelsea as a baby is already a team player giving up or forgoing her own needs for the good of the team. The underlying message is that infant self-sacrifice from birth is the road to family happiness.

Maturana and de Rezepka (1997) have defined love as "making space for the existence of another". These words evoke images of openness, of a welcoming, receptive place beginning to grow and in which a loving relationship is supported. Bringing a new baby into the family requires parents to make space in their physical, psychological and emotional worlds. Yet in Chelsea's family, where a baby is expected to learn that giving is important as receiving, it appears that she is the one who must make accommodations. How many accommodations must she make before she will be deemed to have given enough? It appears that an infant gives by having her physical, cognitive and emotional needs denied. What impact does neglect of her needs have on her emotional health?

The expectation of a "giving" newborn is direct contradiction to the generally accepted consensus that a baby's primary emotional and relational task in the first year of life is to learn to trust, love and attach. Infants learn these attributes by consistently having their needs met by those around them. This occurs when key caregivers *give to* the child. "Caregivers" is a telling term – it is the parents who are labeled the "givers" not the child.

Some of the most compelling evidence of the importance of the infant's learning to trust, love and attach, is the intrinsic memory research by psychologist Daniel Schacter (1997). Intrinsic memory encodes the emotional aspects of early experience mostly in

the prefrontal lobe the brain. This early emotional encoding is important because of the brain structuring that is laid down. These emotional memories are believed to last a lifetime. Although humans cannot consciously recall the events that encoded these emotional memories, the memories serve as a template for how we perceive the world and how we react to later occurrences. Is the world a friendly and nurturing place or an indifferent or even hostile one? Can we trust others to recognize, understand and respond to our needs, or do we need to shut down emotionally to not allow ourselves to be vulnerable? What intrinsic memories are being formed for Chelsea?

How does she learn to trust and therefore develop the capacity to give, if her needs are not met? Instead it is implied her needs are secondary to those around her. Paradoxically it appears that she can best learn generosity through being denied. The implication is also that acceptance and love would be withheld if the parents felt she was not appropriately giving. Withdrawal of love and affection would supposedly be done for her own good and the good of others. Parenting, especially at this young age is normally conceived as a symbiotic but asymmetrical and altruistic relationship. Symbiotic in that the relationship is necessary for both but asymmetrical and altruistic in that adults are providing for the child's needs and not expecting anything in return. Nonetheless it is not without reward.

Anne Lamott describes learning as a parent that giving is its own reward. She learned this single parenting a three year old whom she describes as by turns "wonderful, willful, terrible, crazed and adoring. " She states that having a child taught her both how and what it means to give. She also learned the necessity of giving to children and its intangible rewards.

> And what this three year old teaches you is that you have to give. They teach you to get out of yourself and become a person for someone else.... Your child will hold you hostage, suck you dry, ruin your sleep, mess with your head, treat you like dirt and then you discover they've given you that gold nugget you were looking for all along." p. 204 (Lamott, 1995).

If one agrees with Lamott, for GFI and Babywise parents, it is not only the child that is disadvantaged, it is also the parents. Chelsea's parents would receive few of the rewards that come from being in a loving, and life transforming relationship with a child.

It is very difficult to imagine what tangible things a newborn can give other that her responses of satisfaction when her needs are met. It appears that complete compliance is the "gift" or "giving" that Ezzo expects from children. Statements about infants learning about giving, do not accurately portray the developmental capabilities of infants and may leave parents with extremely erroneous perceptions of what newborns are capable of. Parents are left with an idea that a good child is one who gives up her needs. The good child appears to be compliant and passive. Child abuse advocates agree that the implication that paying attention to an infant's needs will cause a lasting bad " habit" is extremely dangerous message to send to parents.

The description of Chelsea's home life is also reflective of Ezzo's belief that relationships within families are inherently hierarchical with the father-mother relationship taking primacy and the baby learning how to be a good team player by coming in a distance second. In Chelsea's house the infant's developmental and emotional needs are compromised by an approach that ensures that perceived parental needs are addressed while minimizing those of Chelsea. As noted earlier this chapter the narcissistic stance in those claiming to be adults is telling. Is this simply parental selfishness? There is the further implication in this statement and in the rest of the book that a strong marriage would make up for any parenting deficit. Yet most child development experts would disagree "It does not matter how a child observes the emotional closeness of both parents, if the interaction with the child is inappropriate (Goodfriend, 1996, p. 10)

Next in the description of Chelsea, the Babywise authors note that she is a joy to have around. They then mention that "everyone comments on her peace and joy." The first of the two sentences is probably the most telling and begs the question why she is a joy to be around? Is she a joy to be around because she is outwardly compliant and passive? Is her behavior truly reflective of peace and joy, or it is only the passivity of a child who has given up? Is Chelsea a "Stepford" child, outwardly perfect but empty inside, who lacks a natural attachment to her parents? Tyler (2003) suggests that "an Ezzo child is considered to be healthy to the degree that (s)he is compliant without question and obedient to parental demands" (p. 4)

The authors invoke "everyone" (as in everyone comments…) much like a teenager invokes "all my friends". The *argumentum ad populus* strategy of claiming validity for an idea by referring to how many people like it, is usually considered a weak justification at any time. However, in this instance, it also moves the interpretation of Chelsea's behaviour to an external source and away from her parents who should best be able to interpret it. It infers that this child has worth not because of any intrinsic value but because of how others perceive her.

The authors then relate the externally labeled behaviour of "peace and joy" with knowing she is part of the family team and furthermore state that this infant has a sense of belonging and purpose in her life. These are both questionable statements. First, it is difficult to imagine an infant having the intellectual capacity to conceptualize a purpose in life. Second, it is difficult to also imagine how she managed to convey that purpose or its cause to the authors. Again this description unrealistically portrays an infant's capabilities and speciously links this interpretation of the child with the parenting approach. The authors end by implying that what they have labelled *we-ism* will teach her to foster close and loving relationships. *We-ism* although not defined appears to mean disregard for her needs and subservience to the adults in her life. It is widely held that children learn close loving relationships by experiencing them. Maturana et al go as far as to say we can only reenact as adults the emotioning we have lived as a child. Following this premise, if we have not experienced unconditional love and care as a child, what can we truly offer as an adult? What a wonderful prognosis Chelsea has for the future –all because her needs are made secondary to those around her.

This characterization of Chelsea and Marisa continues throughout the book with Marisa becoming colicky, and more demanding. Marisa won't sleep through the night until she is two years old. Marisa is more at risk for child abuse because her mother uses her emotions to make judgments about how she should react to her child. She is also more at risk of developing Attention Deficit Hyperactive Disorder (ADHD). None of these statements have any scientific support. The previous statements are supported only by more of the authors' unique and convoluted reasoning. Further it is implied that Marisa's parents are exhausted and frustrated and their marital relationship is jeopardized.

Ezzo & Bucknam end this segment of the book by appealing to virtues of kindness, honor and respect for others. It is clearly implied that the only path to these virtues is to accept the PDF parenting program. (Similar to declaration of fundamentalist religions that there is only one path to salvation.)

> Every responsible human being has acquired certain virtues useful in getting along well with others. Topping the list are kindness, goodness, charity, honesty, honor and respect for others… However, the acquisition of these traits is not a goal best left to chance. Parents must train these attributes into the heart of their child (Ezzo & Bucknam, 2001a, p. 24).

Strangely these traits do not evolve from living in an atmosphere and with family that is kind, good, respectful and honoring of all humanity regardless of age. Ominously the traits instead must be "trained" into the heart of a child. The Online Etymological Dictionary identifies the earliest meaning (1375) of the verb to train as "draw out and manipulate in order to bring to a desired form". This is certainly the meaning most congruent with the aims of the PDF parenting program. The desired form, or superficial exterior appearance, appears to be the most important outcome to achieve. And if achievement of this form requires manipulation, then so be it imply the Babywise authors. Let the training begin!

Yet how do we best reach the hearts of others? Surely, not through the application of rigid discipline and unquestioning subservience arbitrary rules? From Ezzo's perspective a child only can develop virtue through parental governance and monitoring. There is no trust that in a loving environment, the innate humanity of the child will allow these virtues to evolve. All of the traits Ezzo listed have an eerie resemblance to traits that could be traits that women supposedly demonstrated by being subservient to the men around them.

Questioning the Babywise Science and Logic

In the previous section a number of concerns were raised about the shortcomings of Babywise teachings. These shortcomings include the encouragement of inappropriate expectations of children, misinterpretation of developmentally appropriate behavior and the development of an overly controlling parenting style. Some of the strategies the Babywise authors use to convince their readers of the wisdom of their teachings were

also mentioned. In the following section the strategies, the faulty science and misrepresentations of good science to support their conclusions will be critiqued in more detail.

Overstatement

The 2001 cover promotes the book as "The classic sleep reference guide utilized by over 1,000,000 parents worldwide". The term classic alludes to superiority of this method. Attribution of the term classic to a harsh throwback to decades old and widely discredited child rearing practices is a mark of the unthinking hubris of the authors. Ezzo and Bucknam (2001) rely on the power of numbers to further obfuscate the realities of the parenting approach they advocate. Again the BW authors utilize the *argumentum ad populus* strategy by claiming value for the method by self-naming it a classic and then referring to the numbers who have purchased the book as a mark of credibility of the approach. The authors do not address the many who formerly followed the PDF teaching and now vehemently speak against it (Abel & Abel, ; Hsieh & Hsieh, 1999). It is apparent that they want the readers to accept popularity as evidence for its worth but are unwilling to address the unpopularity of the approach when determining the validity of the content.

They consistently overstate the positive effects and fail to acknowledge the tragic negative effects of the Babywise program. Although hyperbole is common in book jacket quotes and forwards, in Babywise it is taken to new heights. One of the doctors, Sharon Nelson, goes so far as to say "Not following the principles of Babywise is a potential health concern" (Ezzo & Bucknam, 2001a). This of course is contrary to the AAP's caution that using it may result in health concerns (Terner, 2000). In the book's forward, Dr. Bucknam continues the overstatement trend by stating " They [Babywise principles] work consistently …not only for the thousands of children already touched by Growing Families International, but also for my four children, my colleagues' children, my friends' children and now, for all my patients." (p. 15). Anyone experienced with and attentive to children know that there is no approach that works with every child all the time, yet Parent Directed Feeding is presented as a panacea for all the problems a family may have. It not only promises a happy child but perhaps more importantly it promises a

blissful marital relationship that Ezzo promotes as the primary contributor to good parenting.

Ezzo also overstates his personal credentials. He has claimed to hold three academic degrees, when in actuality he has one. He has a Masters of Arts in ministry, which gives significant academic credit for life experience and is a program for non-college graduates. He has remained silent on two occasions, when mistakenly called Dr. Gary Ezzo in public forums (Horner, 2001). Despite no background in medicine, lactation or child development, the prominently displayed M.A. behind his name on the Babywise cover, with no further clarification of the area of study, leaves readers to assume he must have expertise in one of these areas. While it is clear the appearance of credibility is important to Ezzo, he fails to provide supporting evidence. For instance, although he claims to have an medical advisory board of hundreds of physicians but he is unwilling to release their names (Horner, 2001).

While Ezzo tends to overstatement about the "success" of Babywise, he is remarkably silent in those instances where the PDF program was disastrous. Few parents doubt the credibility of the book, which is sanctioned by friends, churches and has medical endorsement. It has fooled well-educated parents. Michelle and Michael Hsieh (1999) provide an anguished description of how they ignored the advice of lactation consultants, nurses and pediatricians in the hospital because they were following what they believed was "medically sanctioned training" from GFI. By four months of age their son was diagnosed as Failure to Thrive (FTT). They began to offer him solid food that he took eagerly. However they also continued to follow the Ezzo's recommendations that a child being fed solids should develop highchair manners and keep their hands below the table. Baby Matthew did learn to do this but his interest in food quickly diminished. He also refused the bottle and cup and began to arch his back and push away when breastfeeding. He was nursing only a couple of minutes every four hours. Ezzo's method does recommend chastisement for this "defiant" behavior but finally the mother's compassion and common sense kicked in and she refused to punish him for the back arching lest he become less interested in food. However he would still only take declining amounts of food and finally quit nursing altogether at nine and half months. He was admitted to hospital for nasogastric feedings and diagnosed as anorexic.

He was on the feeding tube at for five months. At 20 months although off the tube, he had not gained weight (Webb, 2000b).

Medical Credibility

The Hsieh's were following the Preparation for Parenting program because it was church sanctioned and they were convinced of its medical credibility. A quick perusal of the 2001 Babywise edition also leaves the impression of credibility. It is co-authored by a pediatrician, Dr. Bucknam. Dr. Eleanor Womak, the mother of triplets, twins and four singletons is credited with writing the chapter on multiple births. The Medical Advisory board is thanked for their input. The inside cover pages include three pages of testimonials from doctors who personally use Babywise and recommend it to all their patients. Statements like "these well tested principles", "met with tremendous success …minimizing the common problems often associated with breastfeeding", "simply put – it works" from doctors leaves parents to conclude that there is scientific and practical support for the program. Four pages of parent testimonials follow the professional testimonials. The Notes section at the end of the book includes references from well known pediatric and lactation journals and books. Inclusions of all these sources add to the appearance of medical credibility for this latest edition.

Parents however would be unaware that many of the health-care providers who have offered public support for Babywise attribute at least part of their acclaim to their own spiritual beliefs and the religious underpinnings of the PDF program (Granju, 1998). Further, when pressed for the research or scientific data to support their beliefs or recommendations they are unable to supply them or state the research is coming soon (Granju, 1998). For example, Medical Advisory board member Dr. Carl Hays, an obstetrician – concedes that PDF doesn't have widespread medical support but he supports it any way. He believes that frequent nursing doesn't allow the breast to refill and that soon some interesting studies will be published to support this belief (Granju). Although, Dr. Hays can provide no support for his theory other than his beliefs, numerous studies have shown a clear relationship between feeding frequency and optimal milk production (Daly & Hartmann, 1995a, 1995b; Daly, Kent, Owens, & Hartmann, 1996; Daly, Owens, & Hartmann, 1993; DeCarvalho, 1983; Dewey, Heinig, Nommsen, & Lonnderdal, 1991; Egli, Elgi, & Newton, 1961).

Expert opinion is the most powerful when it reflects the consensus among the overwhelming majority of authorities on a subject. Hays, as an obstetrician, would not normally be considered an expert on lactation, but this would not dismiss automatically his contention. However, the burden is on Hays to support his opposition in order to refute the expert evidence. Consistently Hays and others supporting the Babywise books have failed to do so. Gadamer (1981) noted that experts do not absolve us from our own thinking and our own judgements in his essay "The Limitations of the Expert." He states "the more an institutionalized a form of competence is constructed, which proffers the expert, the specialist, as an escape from our own not knowing, the more one covers up the limitations of such information and the necessity of making one's own decisions"(Gadamer, 1981, p. 188).

Most parents reading the book would expect a higher degree of scientific judgment from persons holding medical degrees. They would be unaware that Ezzo and his medical advisor are victims of a selective evidence fallacy where if something concurs with their personal belief then its accepted, if it doesn't its rejected. Readers of the secular versions particularly would be unaware of the extent of personal stake in PDF these doctors have. It appears that they adhere so strongly to the GFI religious beliefs, they can ignore or dismiss the well-documented concerns about its content and impact. It appears they have too much stake in the religious message to fairly assess any scientific evidence. It is reminiscent of the Intelligent Design debate that is currently occurring in the USA. Once again religion and personal beliefs are conflated with science.

In 1998, the president of the American Academy of Pediatrics, Joseph Zanga, personally invited Dr. Robert Bucknam to publish the Babywise findings in the *AAP News*. In an article published in May 1998, Bucknam reports no cases of FTT and/or dehydration in any of the more than 2000 babies in his practice. Dr. Steven Rein, a PhD in Statistics, and operator of the www.ezzo.info website points out the unlikely probability of this occurring.

Various experts have estimated that FTT and/or dehydration occur in no less than 1% of babies and probably much more frequently. Using the 1% as a minimum occurrence rate, it would be expected Dr. Bucknam would have seen at least 200 cases. Rein goes on to state that if Bucknam has seen none, we are left to conclude that either he

isn't correctly diagnosing the cases or that his PDF method is helpful at reducing FTT and dehydration **and** he is luckier than the person who wins the Virginia Lotto drawing three weeks in a row. Rein concludes by saying it more likely "that he hasn't see a FTT or dehydration case he would *attribute* to his PDF schedule."(Rein, 1999) (emphasis mine).

Parents would also be unaware that despite Dr. Bucknam's credentials as a pediatrician he appears to lack the statistical and scientific knowledge to appropriately evaluate research. Bucknam includes descriptive and frequency statistics in the 2001 copy of the book. These are the same 'studies' he presented in his 1998 response to the AAP news. He mentions large sample sizes and impressive numbers to indicate the success of the PDF method (97% of the 520 infants slept through the night at 12 weeks) (Ezzo & Bucknam, 2001a, p. p. 51). What most parents wouldn't question is how this data was obtained. None of the data that Bucknam cites on PDF infants has been published in any professional publication and there is no indication that these 'studies' were peer reviewed for research rigor or ethical conduct. Without more information than the extremely high figures (97%) Bucknam presents it is difficult to draw any conclusions. Rather only questions are raised.

First Bucknam's report appears to be about a retrospective study. Retrospective studies have considerable limitations because of the difficulty identifying and controlling variables after the fact. Further, measuring the variables accurately in after the event is also difficult. Stringent measures are also needed to ensure a representative sample to increase the validity and reliability of the studies findings. How were the 520 babies reported sampled in the Bucknam report? Bucknam indicates that they were volunteers from GFI followers. This means they were committed GFI and PDF followers and would not be a representative sample of the general population. Even if the sample was representative sample of those following PDF, it cannot be said that PDF helps babies sleep through the night without the presence of a control group. It appeared that the length of sleep was measured based on parental recall. How long after the child was twelve weeks old were the parents asked about the infants sleeping patterns? What was considered sleeping through the night? Would an infant who woke in the night and whose parents didn't not respond to his/her fussing be considered to have slept through

the night?

Even if PDF did help infants sleep through the night, it doesn't mean that it would be a good thing to use. Despite reports from many lactation consultants and physicians seeing FTT and dehydrated babies, poor weight gain and milk production problems for mothers when following PDF guidelines (Aney, 1998; Auerbach, 1998; Terner & Miller, 1998), no downside to PDF is included in the Babywise books. Given the seriousness of the documented problems, the Babywise authors' error of omission is reprehensible. If parents knew the story of baby Matthew Hsieh or that a proportion of infants on the PDF schedule have developed FTT and/or dehydration or that it may compromise the mother's milk supply would they follow PDF so keenly and blindly? If all the facts were available, the 97% rate of nighttime sleeping would be far less tempting to parents. Without the inclusion of contrary data, parents unfamiliar with research methods would be unlikely question the research or the author's conclusions. The overwhelmingly message of statistics in Babywise is that this method works and is credible.

In addition to inclusion of questionable but "impressive" statistics, the Babywise authors use other strategies to create the façade of credibility. One of there most common strategies is the creation of a fact and its theoretical rationale. An example is the statement below:

> Here's the good news. Babies under the parent-directed feeding plan tend to cry less in the long run than babies who are demand fed. Why? Infants on a routine grow confident and secure in that routine. There lives have order and they learn the lesson of flexibility early in life (Ezzo & Bucknam, 2001a, p. 141).

They assert this without any documentation. It is a rather startling statement from authors who state that a newborn must feed, have wake or play time and then nap for one and half hours. If the infant does not want to sleep/nap at the prescribed time it is recommended to let the child cry for 15 to 20 minutes. Given this recommended schedule an infant could cry for up to two hours and forty minutes a day going to sleep. Then since infants are also to be fed on schedule they could also cry for another significant period of time, if they awaken with hunger prior to the scheduled time. The

authors go on to say that never letting a baby cry is the way to ensure a fussy baby.

These statements are directly contrary to both the research and commonsense. Anderson (1989) found newborns who were left to cry had heart rates that reached worrisome levels and lowered oxygen levels in their blood. When the infants were soothed, their cardiovascular system quickly returned to normal. Further crying babies who are consistently responded to within ninety seconds end up crying 70% less, than whose parents allowed them to cry for longer periods of time (Taubman, 1984). The Australian Association for Infant Mental Health Inc. Position Paper on Controlled Crying states "Crying is signal of distress or discomfort for an infant or young child. Although controlled crying can stop children from crying, it teach child not to seek or expect support when distressed.... Infants whose parents respond to and attend to their crying promptly, learn to settle more quickly in the long run as they become secure in the knowledge that their needs for emotional comfort will be met" (AAIMHII, March 2004).

Appeal to a Credible Resource

Another strategy of the Babywise authors is using a credible resource and then misrepresenting it to bolster their perspective. This is contrary to the primary characteristics of accurate evidence. These characteristics are that the original reference either quoted or paraphrased accurately and it is presented with its original meaning and intent intact. An example of BW misrepresentation of a credible source:

> How often you should feed your baby depends on your baby's age. As a general rule you should feed your baby approximately 2 and a half to 3 hours from the beginning of one feed to the beginning of the next. With these recommended times you can average between eight to ten feedings a day in the early weeks. These times fall well within the recommendations of the American Academy of Pediatrics (Ezzo & Bucknam, 2001a, p. p. 74).

What the AAP statements actually says is that mothers should nurse when the infant cues his/her hunger. Hunger has less to do with the baby's age and the clock, than with the size of the baby's stomach, the baby's metabolism, activity level, growth spurts, the efficiency of the baby's milk transfer, maternal breast milk storage capacity, and the

daily fluctuations of her milk supply. Further the AAP recommendations state that feeding when hungry will result in 8-12 feedings daily on average. Although is true that "eight to ten feedings" falls between the 8 and 12, the above BW discussion is not in keeping with the spirit and intent of the AAP recommendations that actually recommends feeding a hungry baby on occasion more than 12 times a day (Thile, 2005).

Misrepresentation of Opposing Views

Examples of final major strategy of the BW authors are found in the previous section analyzing the narrative representations of babies Marisa and Chelsea. First the author uses his own peculiar definitions to describe widely understood and clearly defined subjects such as attachment or child centred parenting and demand feeding. After the authors redefine well established and widely accepted terms, they then misstate the evidence that supports such ideas and mischaracterize the arguments of the experts with whom they disagree. In doing so, they create an imaginary concept to demonize or alternatively prop up their argument. In the process they fail to address the real thing they are claiming to discuss. Rather they use their false portrayal to vilify the concept and the persons using it. One respondent to a web message board on the Ezzo Parenting Debate describes it this way "Ezzo, at times, reminds me of the Cheshire cat in *Alice in Wonderland,* who said to Alice: "When I use a word, it means exactly what I want it to mean, and nothing else." (Metochoi, 11/19/2001 retrieved February 13, 2006).

This particular ploy has been in play since the publication of the first BW in 1993. For over a decade Ezzo et al have failed to respond to the substance of the criticisms or deal with issues brought up by critics (Terner, & Miller, 1998; Terner, 2000)

Sometimes strategies are creatively combined. In what appears to an attempt to promote PDF as a middle way, the authors create a new category. They begin by redefining child-led feeding and misrepresent its content and intent. For example in their definition of child led feeding, they state "The constant of time is never considered, because the theory insists that the parents submit to the baby's hunger cue regardless of the lapse of time" (Ezzo & Bucknam, 2001, p. 36.) Note the pejorative statement – "parents submit" - not "parents respond. Next note the inaccurate statement – time is never considered. They further their misinterpretation by mentioning mothers could be feeding every hour or even at 20-minute intervals. They then create a new category which

is equally rigid – Clock feeding. The clock determines when the infant is feed and the variable of hunger cues is not considered. Here the pejorative language is used once again. "The parents role is submissive to the clock" (p. 37). Once these two creations are completed, Parent Directed Feeding becomes the moderate way to feed a child.

Another example of their creative use of terms is in their redefinition of the word flexible.

> But what is flexibility? Many times we hear new moms say they want to be flexible. What does this look like? The word flexibility means the ability to bend or be pliable. When you think of a flexible item, you think of something with a particular shape that can bend and then return to its original shape. Returning to its shape is perhaps the most crucial dimension of flexibility. During the first critical weeks of stabilization you are giving your baby's routine its shape. Too much flexibility in these weeks is viewed by the baby as inconsistency. Routine must first be established (Ezzo & Bucknam, 2001, p. 109).

Here routine is given primacy over flexibility. Routine must also be returned to preferably sooner than later. Feedings are primarily associated with clocked intervals, not the baby's hunger. In later examples of when the mother might be flexible with her feeding schedule, the example of an appropriate times to alter the schedule are related to being in public which implies the schedule would be followed at home. Thus flexibility is only for public and not private use. The other example given of a time for flexibility is to allay the discomfort of adults around the child. None of the examples of "flexibility" deal with hunger or the baby's needs. Flexibility or diversion from the schedule appears to be driven solely by adult comfort (Thile, 2005). Once again the AAP message about feeding a hungry baby is undermined by conflicting messages about flexibility. "Real flexibility adapts to the circumstances, turning away- sometimes permanently-from preconceived plans" (Thile, p. 3). Ezzo raises the idea of "flexibility" for appearances and to create the representation of PDF as the moderate way.

Interlude and reflection

Over and over again I found more instances of Ezzo's unconscionable and dishonorable practices. I was stunned, shocked and overwhelmed by the sheer audacity

of Ezzo's intellectual and personal dishonesty and misrepresentation, his cowardly bully tactics in the face of criticism, and the harm that his books and teachings have brought to children and families. His lack of integrity defies comprehension. The sheer audacity of his actions initially drew me away from a hermeneutic questioning of the Babywise text. The next section of this chapter is a beginning hermeneutic examination and understanding of the work. This questioning will address not only the meaning of Ezzo's statements but how they function to create specific social effects.

Questioning the Babywise World

All parenting approaches encapsulate a social vision, not always explicit but a vision nonetheless of human nature, child development, socialization and social structures (Gore, 1993). Indirectly this vision speaks of what it means to be human in society. Likewise the hermeneutic philosophers also had a vision of what it meant to be human and experience the world. This chapter begins with a short discussion of Heidegger and Gadamer's view and contrasts their viewpoint with Ezzo's approach.

Heidegger's primary hermeneutic interest was inquiry into *Dasein* (translated *da* – here, *sein* – to be). Gelven (1989) states the most etmologically correct translation of *Dasein* is "to be here" (p. 27). He further noted that J. Glenn Gray believed that the basic meaning of *Dasein is "openness"*, so the translation of *da* should be read in the sense *"Here* I am open to possibilities!" (p. 27). Heidegger's discussion of understanding in Being and Time gives possibility priority over actuality. Dasein because of it ability- to-be (Seinkönnen) is an always unfinished product (Heidegger, 1927/1996). Further we are aware of our possibilities (Gelven p.87) and this awareness calls us forward to greater understanding and the opening of more and greater possibilities.

> Gadamer also stressed the fundamental openness of human experience:
> The way we experience one another, the way we experience historical traditions, the way we experience the natural giveness of our existence and of our world, constitute a truly hermeneutic universe, in which we are not imprisoned, as if behind insurmountable barriers, but to which we are opened.
> (Gadamer, 1999, p. xxiv).

Both Heidegger and Gadamer describe the essential hermeneutic nature of human life – that is a life of possibility and openness. Being open to life means acknowledge that life is contingent and cannot be controlled. There are always unknowns ahead and because of this a multitude of possible reactions. Thus my questioning examines the meaning of Ezzo's words in contrast to the world as viewed by these hermeneutic thinkers.

Ezzo, in contrast to Gadamer, actually advocates a radically un-hermeneutic universe. As described in detail in the first section of this chapter, Ezzo does not want meaning for those following the Babywise precepts to come through dialogue and process. Rather Ezzo attempts to arbitrarily decide meaning and impart his meaning to the world as fact. He attempts to replace the process of understanding with the transfer of rules to the ruled. For Ezzo our relationships do not evolve and change. Rather our relationships can be dictated and directed. For Ezzo the world is a place where meaning need not be sought, for it is a world is already predetermined and given.

The following section will discuss some of the ideas inherent in the Babywise discourse and the perspectives the discourse enforces, sustains and privileges. For ease of discussion I have chosen to limit my focus to four elements of the Babywise discourse, acknowledging awareness of a plethora of other elements, assertions and meanings that arise from the discourse.

Discourses

Discourses offer both a social vision and as well as instructions to achieve the vision (Gore, 1993). In Babywise, while the instructions are explicit, the social visions embedded in these instructions are less so. Although Babywise may not be the actual book that the mother in the opening vignette read, it is representative of a worldview of parenting, breastfeeding and parenting instructions that are common. The Babywise discourse recreates and reflects a number of powerful and interrelated social, cultural, gender, and political discourses. Examination of Babywise brings forward societal troupes about children, parents, power and control and merits further discussion

Meaning in the name Babywise

The Babywise name itself is telling. The authors purport that the name refers to becoming knowledgeable about the ways of babies. However, the words "becoming

knowledgeable" or wise suggest change and movement. Wisdom or becoming wise in many traditions is dependent on transformative change. We become wise as we learn better and new ways to respond to that which we cannot control. We become wise when we become humble before that which we cannot change. Iyengar speaking on the development of wisdom in the yogic tradition speaks of the force of yogic action: "It is transformative. It does not just change the way we see things; it transforms the person who sees. It brings knowledge and elevates it to wisdom" (Iyengar, Evans, & Abrams, 2005) (p. xxi). Wisdom requires personal change and evolution. One would expect that similar thoughtful, questioning parental action is required for the development of parental wisdom. Yet Babywise requires no transformative change of parents and actually advocates maintenance of the parental status quo.

Bergum (1997) describes *the science of wisdom* as the an attempt to "reveal knowledge to show us how to live rather than to pin down knowledge in order to control life." (p. 135). In contrast Ezzo tells parents they must take control and intimating if they don't, there are grave physiological and behavioral problems for their children. The message is children need control, rather than children need support and guidance.

Ezzo sells control as the antidote to freedom and its associated problems. If Marisa wakes during the night, it is not because she is hungry. Ezzo states she waking because she is experiencing discomfort from her parents not providing enough structure in her life. In other venues Ezzo has labeled this "developmental confusion" as a result of "excessive freedom". When asked to define this term Ezzo could only say when it occurs but not what it is. "Developmental confusion happens when a child gets more freedom that he or she is ready for" (Webb, 2000a, p. 19). PDF makes it clear how problematic it is to allow a baby the freedom to eat when he/she is hungry or sleep when tired. When a child is doing developmentally normal activities, it has too much freedom! Babywise delivers information to primarily to control – both children and parents.

Smith has said that becoming wise requires us to address the condition of our own ignorance (1999). Thus, true wisdom requires a certain self-reflexivity and questioning of self. Maezen Miller (2006) describes the consequences of not addressing your ignorance as a parent:

> ...Your child has arrived and the battle has been joined. It is the battle to the death of your ego. The demise of your selfishness and impatience. The end of your idle distractions and carelessness. The decline and fall of Numero Uno. Or so you must pray, because in this contest, you must lose and lose quickly. Pray that you will never bear the shattered consequences of winning when your child's safety, trust and happiness are the casualties. (p. 30).

As mentioned earlier in the chapter the "wisdom" offered in Babywise allows for no questioning of self, of the church, or of Ezzo. The "wisdom" of Ezzo demands instead unquestioning adherence to the Babywise injunctions. The good parent is the rendered the unquestioning parent. In Babywise, to have questions is to doubt and to doubt is to fail as a parent. To have questions would demand that the closed and fixed structure that Ezzo defines as good parenting open up, and becomes responsive. To have questions, is to threaten the rigid sureness of certainty that Ezzo has surrounded himself with and which appears to sustain his empire.

Ezzo maintains his pillar of certainty by casting all difficulties and problems back on the parents. So if the Babywise prescriptions don't result in the outcome promised, the problem lies with individual following the prescriptions and not the content or ontology of the prescription. For example Ezzo falsely suggests eight-week old infants should be sleeping seven to eight hours a night "if the program has been implemented properly". As a result, parents are left to wonder what's wrong with them or their baby when it does not conform to this erroneous "norm". In the Babywise representations of parenting, the mother and her infant become the site of problems with the feared outcome being a disobedient and unruly child who will never grow up to function in the adult world. As Babywise allows no room for questioning or self-reflection, there is little room for real wisdom to grow. Privileging the theory over the direct experience of having a baby living with you.

Alternatively, the name Babywise implies that parents need to become wise to babies. But what does it mean to become wise in this sense? As in the term "streetwise", wise here implies a savvy ness, a shrewdness, an ability not to be taken in by those who are out to trick or take advantage of us. This understanding of the name Babywise, places

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babies in an adversarial relation with their parents and further suggests that babies are conniving and manipulative rather authentic and vulnerable. The title carries the further implication that world is not a safe place and protection from the travails of the world lies not in complementary relations with others but in individual wariness of the Other.

The Meaning of Children in the Babywise Discourse.

"They have been offered a seemingly rational plan for child-care that is full of misinformation, denial, and disguised child-hate" (Scott as cited in Granju, 1998, p. 7).

Strong words – misinformation, denial and disguised child- hate. The misinformation and denial have been discussed earlier in the chapter, thus the focus of this section will be child-hate. Where are the indications of child hate in the Babywise literature? The child-hate referred to above lies in Babywise's replication and extension of long held perspectives on children as incomplete, deficient and therefore problematic (Miller, 1983). Further Babywise appeals to rationality as the primary arbiter of human life. Just as "rational man" has attempted to sever his ties to the natural world, so does rationality act to sever ties with children (Jardine, 1998b). As a result Babywise and similar narratives result in "a pedagogy which, while passed on as being for "the good of the children" does not recognize the violence against children inherent in its own claim" (Smith, 1999a, p. 136). Examination and deconstruction of the Babywise discourse reminds us not only of the "limits and dangers" (Jardine, p. 104) we face in this construction of the concept of child but also the limits and dangers that exist in all of our constructions of children.

Ezzo's pronouncements are centred on a social (political, religious) vision of what a child should become rather than guidelines for parental practice. Guidelines for a responsive and open parental practice would focus on how parents might come to live their child. That is, how to live with a unique human being presented before them. Instead, the repressive myths that accompany Ezzo's rhetoric about raising responsible children, serve to lump all children together. The roots of child hatred lie in the construction of a category (Jardine, 1998b; Smith, 1999b) or class for children that is different from and usually considered lacking or less than that of adults (Hall, 1999). Grounded in a form of Kantian logic, in this view, children do not have meaning of their own. It is only through our activities as adults that children come to have meaning

(Jardine, 1998b). We assign qualities to individual children on the basis of their inclusion in our adult constructed alterity. Thus children as categorized by adults become immature, undiscerning, irrational, inattentive, unreasonable, and unruly etc. Further this categorization of the child can be manipulated to serve the aims of society, victimizing the child in the process (Smith, 1999c). Structures in society (such a schools, parenting education programs) are then created to deal with "the lack (s)" that the category of child displays.

The child psychiatrist Alice Miller stated "Children are messengers to us from a world we once deeply knew" (Miller, as cited in The Sun 2007). Adult forgetfulness can make children seem alien and unfathomable. As an alien and separate from us, it is easy for the child to become an object. Once an object, the category child can be subjected to the rational analysis of adults. As adults, who have forgotten this world we once knew, the qualities of children can be rejected, feared and disowned. In the instance of children, the qualities of vulnerability, dependence, even the child's very uniqueness can be feared. This fear keeps us from seeing the sameness, the interdependence, and the relatedness that we have with our children. Often that which we fear, avoid, deny, or disown – makes us uncomfortable and we must assuage our discomfort by attempting to control it. Yet all that we reject, fear and disown also keeps us from compassion. If we can see those things (vulnerability, dependence, weakness, etc.) in ourselves, then our hearts can become open to others (Chodron, 2002). So denial of these attributes in children, these messengers from a world we once knew, is also denial of the opportunity for parents and adults to become compassionate beings and to acknowledge the fullness of possibility

The Meaning of the Parent-child Relationship in Babywise.

What inheres in Ezzo's Babywise proclamations? There is an adult arrogance towards children. There is the belief that children only have meaning through adult interactions with them. In a stunning feat of cultural alterity, Ezzo and his pronouncements serve to sever the relationship between parent and child – creating a duality that Ezzo forbids us to bridge at our children's peril. Relationships between adults and children are no longer seen as a "deeply communal act" (Jardine, 1998c, p. 126) but rather have become an exercise in management and control.

Thus there is no need to read the signs of the child. The signs of the child are rendered insignificant and without meaning. So Chelsea's shyness around strangers, as mentioned in the previous section, is not to be examined, and viewed with tenderness. The meaning of her shyness has already been predetermined as a lack or deficit to be removed or controlled. Likewise there was no need to read the signs of the child at the Breastfeeding Centre when he awoke during the night. It had been predetermined that nine month olds should not wake during the night – so there was no other meaning that the mother could attribute to her child's behavior.

In Ezzo's ordered and controlled world, parenting becomes a primarily mindless janitorial and custodial work. In today's busy and overscheduled lives, order and control are seductive themes for parents. There is no time to reflect on the limitations of purely custodial care.

Although play time and time with mom and dad are mentioned as part of the PDF schedule, the spontaneous games and interactions that erupt between parent and child throughout the day, become secondary to feed, wake and sleep times. The schedule diverts the mother's natural attentiveness and alertness away from the child's cues and focuses them on the clock. In the schedule there is no learning without teaching. In the parent directed feeding world there is only the teaching of routine, of order, of obedience, of manners, and of "virtue". Yet what can never be duplicated or replaced is the learning that occurs without teaching. That is, the learning enabled and enriched by the sheer loving responsiveness of an adult to the child in his/her fullness. That is a responsiveness to the child already there, not some mythical child to be molded and shaped.

Smith (1983) in his doctoral dissertation, *The meaning of children in the lives of adults*, speaks of the insistent voice of children. Children are a persistent presence in the adult world. They are a presence that calls adults to learn, to change. He also speaks of the need of children to have a space that will receive them and awareness "that children contain within themselves something the adult world can never know." p. 242. "Living with children for an adult means living in the ambiguity between the known and the unknown. …Rather, 'living together' with children requires the upholding of a hope that what is beyond oneself will still be there for oneself in spite of its otherness." p. 243. Smiths reference to 'living together' infers a partnership that Ezzo prescription for

parenting denies. In Ezzo's world, parents and children may inhabit the same space, but they do not "together" live.

The categorization to the class of child or infant defies the parent to think of their child in an ecological manner. To think ecologically about our children, is to stress our linkages and our interdependence. It focuses us on harmonizing with our children rather than controlling them. "Thus, ecology concerns not what we can do…., but what is properly responsive to the place in which we find ourselves, those actions which have a sense of propriety, those actions which are fitting" (Jardine, 1998b). Jardine cautions against categorizations that stress separateness rather than mutuality with our children, stressing the implications that this emphasis has for not only our children but for the whole ecosystem we live in and are a part of.

> …work in educational inquiry begins with an implicit, unvoiced repudiation of childhood. Such a repudiation might make it possible to render children into a controllable, predictable and manageable *object,* and such rendering certainly has a place in our living relationships with children. But it at once rends the tenuous, ambiguous threads that make children our "kin", our "kind" and that makes us and our children *of* the Earth. In striving to break these threads in the name of a Reason able to act without guidance or hesitation or any sense of "kind-ness" towards what comes to meet it, ecological disaster is already foretold. (Jardine, 1998a, p. 13)

Heidegger describes our choices in interacting with the earth, our *eco*, and the possibility of being truly at home in our environment.

> It is one thing to just use the Earth, another to receive the blessing of the Earth and to become at home in the law of this reception in order to shepherd the mystery and watch over the inviolability of the possible (Heidegger 1936-46, 1987 p. 109).

Both Jardine and Heidegger acknowledge the various ways we can enact our relationship with the Earth and the consequences our interactions portend. To "shepherd" can mean to direct and also to care for. As it is impossible to direct a mystery or the ineffable, it is clear that Heidegger is asking us to care for the mystery and not attempt to

impose direction, control and in the process to shut down possibility and the future well-being of the Earth.

Both authors ask us to look beyond a purely functional relationship with the Earth and our fellow inhabitants. They ask us to see that a deeper and more thoughtful relationship with the Earth that can enrich our lives and also protect the Earth. To be at home in receiving the blessing of the earth is to react in ecological ways with our children. It is to move beyond certainty and control and to protect and nurture "the possible" in our interactions with children and our interactions with the Earth.

To interact with children in an ecological way calls us to acknowledge the similarities, connections, distinctions and differences of our children, that is to acknowledge their wholeness. It requires parents to say "You are of me but not mine, you are from me, but you are not me. You are you – integral, whole, being and becoming Because of this I cherish you not as some incomplete, not yet formed entity but as you – you, like the world, that are always already here! (to paraphrase Gadamer, Heidegger, Jardine, Smith). A child already here – a child not needing to be modeled into a prescribed stereotype of the good child but a child here, integral and whole in their becoming. The child already here is also the child of the here and now and of the present moment. That is an unique child to be responded to authentically.

To relate to our children in an ecological way can also be thought of as relating to our children in a more soulful way. The word soul is Sanskrit for abiding reality.

> We rightly associate this abiding reality with selfless love, which is founded the perception of unity, not difference. The strength of a mother's love derives from her unity with the child. In unity there is no possession, as possession is a dual state, containing me and it (Iyengar et al., 2005, p. 9).

Thus to be soulful in parenting or in our interactions with children is to acknowledge all that unifies us as well as what differentiates us from our children. To be soulful demands that we don't allow what is different to separate us. To act in a soulful way, puts us in "right relationship" with our children. It calls us to act not from isolated and unthinking reason or from the desire to control. Rather it causes us to act in ways that acknowledge our kinship, the ties that bind and to act in concern with that which

connects and unifies us with our children. To be soulful, allows us to acknowledge the abiding reality of our differences but also the reality of our sameness, without the dominance of either perspective.

Meaning of Discourses of Control and Power.

What purposes are served by discourses that represent children and the parent – child relationship in the manner described above? Classifications or categorization such as these are usually a means to a political end (Allen, 2001). Certainly the Babywise discourse reinforces long-standing social, cultural and gendered understandings about the nature of power and the need for control. As a result the Babywise discourses about the meaning of children and the nature of the parent-child relationship serve to reinforce a particular hegemony. The following section will begin by examining control and power as is played out in Babywise.

Wendel Berry (Jardine, 1998c) contrasted the notion of chaos and the notion of mystery. From the chaos perspective, humans give order to things and anything not ordered by humans is out of control. Alternatively the notion of mystery acknowledges that what we know and can know is limited but what is beyond our knowing "contains implicate patterns and relationships which have their own integrity, which are not of our making" (Jardine, 1998b, p. 119). It is clear that Babywise subscribes to the notion of chaos in our world. For example, the Babywise prescription for children, for mothers and fathers that despite giving lip service to flexibility, is primarily about control and imposing order.

The Babywise prescription when linked with the forces of fear and moral or religious injunction is at its most powerful. Foucault (1980) has called for an examination of power:

> the longer I continue, the more it seems to me that the formations of discourses and the genealogy of knowledge need to be analyzed, not in terms of consciousness, modes of perception and forms of ideology, but in terms of tactics and strategies of power (p. 77).

Some of Ezzo's tactics and practices have been described earlier in the chapter. Ezzo powerfully uses fear and appeal to both religious and moral concerns to bring parents in line with his injunctions. The dual strategies of encouraging fear and the appeal

to religion or morality are visible in a deep reading of his work. Power "emerges from specific practices in local arenas of action" (Gore, 1993, p. 58). The specific Babywise practices of the creation of fear and appeal to morality in the arena of parenting will be discussed.

Although the religious references are removed, the Babywise authors still create a moral subtext (Thile, 2005) that can distract parents from feeding a hungry baby, or letting a sleepy baby sleep. Here is an example:

> Since most babies do not have the ability to organize their own sleep into a healthy pattern, parents must take the lead. Here is where parenting begins with wise decisions in the best interest of your child. Consider the alternative. Is the parent's job simply to respond to an infant's demands? When, then, would this concept switch over to allow the parents to direct the child? Toddler years? Preteen or teen years? Hardly. By then you've missed the boat, and your child sails full speed ahead oblivious to fundamental skill like falling asleep comfortably alone (Ezzo & Bucknam, 2001a, p. 26)

The authors begin with an inaccurate statement that appears to be based on their erroneous belief that healthy patterns in newborns mimic their parents night-time sleeping patterns. They further tap into to parents' sense of responsibility for the child by telling parents that they must be leaders and make wise decisions. "On Becoming Babywise is more than an infant-management concept; it is a mind-set for responsible parenthood" (Ezzo & Bucknam, 2001a, p. 17). Parents are left with the implication that all other approaches are irresponsible. Further it is implied that being truly responsive to their infant does not equate with responsible parenting.

In the Babywise discourse, the 'who' parents hold primary allegiance shifts away from the infant to an external force (Foucault, 1995) – which appears to be "God" in the religious versions and appears to be "they" or culture in the secular version. As Foucault (1995) has described the personal internalization of power in his presentation of Bentham's architectural Panoptican:

> He [sic] who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself: he inscribes in himself the power relation in

> which he simultaneously plays both roles; he becomes the principle of his own subjection (pp. 202-203).

For religious parents, religion is the overseer of the field of visibility described a by Foucault. Loy (2003) describes religion as providing a 'reassuring worldview – a sacred canopy – that provides psychic and social stability" (p. 3). He goes on to note with postmodernism has come the recognition, that the subjective canopies provided by religions, are in fact human creations. Thus it is not God's power but rather the power bestowed by the parents on God and Ezzo, as the purveyor of God's word, that subjugates these parents. Gore (1993) has called this a regime without a master, a regime that can terrify and control because of the power the individual has assigned to it. For non religious parents, power is given to the ever powerful cultural "they" as in "they say children should be seen and not heard". Parents seem to be fearful of their own ignorance. They are unwilling to trust themselves to feel their way into this new life with their new infant. Thus the tactic that Ezzo uses is create and highlight fear and the panacea that Ezzo offers for this parental fear, vulnerability and ignorance is control.

Conclusion

It is important to note that all discourses are more nuanced and fluid than it would appear in this discussion. Although I postulate that Ezzo's discourse is generally problematic and of great concern, I do not wish to fall into a good-bad simplification of the discourse. Foucault (1980) argued:

> We must not imagine a world of discourse divided between the accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that come into play in various strategies....Discourses are not once and for all subservient to power or raised up against it, any more than silences are. We must make allowances for the complex and unstable process whereby discourse can be both and instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it ... There is not, on one side, a discourse of power, and opposite it another discourse that runs counter to it. Discourses are tactical

> elements or blocks operating in the field of force relations; there can exist difference and even contradictory discourses within the same strategy; they can, on the contrary, circulate without change their form from one strategy, to another opposing strategy (pp. 100-102).

The Babywise phenomenon and discourse has been shown to be an instrument and an effect of power and control in the lives of new parents, breastfeeding mothers and infants. This chapter is my contribution to the complex and unstable process of the Babywise discourse as it plays out in the world. It is my hope that naming and showing the discourse will undermine it and render it more fragile. This chapter examining Babywise and its associated discourses serves as an introduction to the explication of a new more nourishing milieu for mothers and infants as described in the following chapter. The chapter also serves as starting point for an opposing strategy to the Babywise discourse.

CHAPTER SIX

LIVING AMONGST THE DISCOURSES: WHATEVER WORKS IN YOUR HOUSE

Babywise represents one deeply polarized and polarizing view of breastfeeding and parenting. What is powerfully present and evidenced in the experience of the mothers and nurses at the Breastfeeding Centre stands in stark contrast to the view of parenting and breastfeeding Ezzo proposes. The following chapter begins by illustrating and describing the conditions and ontological perspective that allows a sense of truth to arise at the Breastfeeding Centre. The multiple components and the many-sidedeness of the ongoing lives of mothers and nurses are revealed. The components presented may seem randomly organized because they tend to coexist jostling together in ever changing patterns and groupings where foreground becomes background and partnering or sequencing of components vary from moment to moment. Like actual life, which can best be conceptualized a shifting phantasmagoria, this work does not attempt to freeze these ideas into a model or linear process. Rather, the intent of the next section is to *show* the experience so the reader can begin to better discern the flux of life as lived for mothers and nurses and how this may influence our understanding of truth.

Whatever Works in Your House

This section begins with "whatever works in your house" because the statement encompasses both the core and the whole of how the nurses approach and work with the mothers. During personal conversations with the nurses, I asked them to reflect upon their interactions with the mothers at the breastfeeding centre and to reflect upon the nurse-mother relationship. One nurse/lactation consultant Gwen began our discussion with the following statement.

> *I think because they are a healthy population, they come with their questions, with their own sense of truth. My epitaph will be "Whatever works in your house."*

An epitaph, whether inscribed on a tombstone, or delivered as a short eulogy at a funeral is meant to capture the essence of a person's life and values. An epitaph is descriptive. It is a statement of how a person has lived their life but also a statement that encompasses how they want to be remembered. While the nurse jokingly states the personal importance that she attributes to this particular approach to her work with

mothers, that she chose this element of her work to sum up her work speaks to the centrality of this stance in the nurse's relationship with the mothers. Her personal commitment and the way she wishes to be remembered is her orientation to the mother's questions, the mother's sense of truth - the mother's home and the mother's grounding.

The Whatever Works in Your House statement points to and underscores all dimensions of the nurses' work at the Breastfeeding Centre. This statement or its derivatives –"what will work for you?" "what is important for you?" "what's going on for you at home?' are consistently used by the nurses. The statements envelop the nurses' approach to the mothers and their ontological orientation to nursing practice. The nurse who requested the "Whatever works in your house" epitaph went on to say "*They come with questions, and their own sense of truth*". Their questions become the beginning point for discussion – the questions that the mother brings and the mother's sense of what is important for her and her child. The nurse's statement is an acknowledgement that truth does not reside with one person and that to seek truth a dialogue must begin. The mothers' questions begin and direct, sustain and invigorate the dialogue between nurses and mothers. The nurse's questions in turn reach deeper and deeper into the experience of the mothers, calling forth richness and complexity.

Questions

In this dialogical relationship, the questions flow from the mothers. *What do you think this rash is? Why does he pull off the breast after only five minutes? Is she getting enough milk? Why does this hurt? She seems to be choking every time she feeds – what can I do? Look at all those rolls, do you think she's getting too fat? Why aren't I producing enough milk? I have a hard spot on my left breast – could you take a look at it? How often should I feed?*

The scope of the mothers' questions is vast and the mothers appear to have little hesitancy in asking. The Breastfeeding Centre is a setting where anything can be opened for discussion. As one mother said *"I like that I can ask them anything and they know the answers. They know everything about babies."* Sally with wonder in her voice laughingly said "*You could just say whatever, and it didn't shock them*". Another mother stated " *I can say anything to Betty.*" The responsiveness of the nurse to Sally's questions calmed her during her first days at home with her new baby.

It felt like they actually cared, and I didn't feel like they'd done it a million times, which was amazing to me, because I'm sure they had. Just good information, 'cause I had a million questions, which I can't remember now, but they just kept answering the questions.

Questions keep the dynamic open and moving. The mothers' questions direct the course of the dialogue. The nurses' questions acknowledge that the difficulties of life are omnipresent but need not be overwhelming. Questions keep possibility in the forefront. Unlike the labeling of a problem, questions maintain the fluidity of the woman's life. To pinpoint and label a difficulty as a problem to be solved, shifts the dynamic to static and can reduce the mother's experience to the banal and the common. The labeling of a fixed encapsulated problem can narrow the experiences of life to a threadlike specter of their original vitality.

Our lives are greatly influenced by the technical-scientific discourse and the use of technology and science to solve problems. Jardine (2000a, p. 30) describes the current predominant technical–scientific discourse as one that "offers itself up as a *remedy* to the difficulties of life" (p. 117). The orientation is towards fixing difficulties rather than living our lives. The technical-scientific discourse represents the world as something to dominate and hold at a distance.

Burch (1986) describes the situation "The world as context in which we dwell is lost." (p. 6.). The tendency of the predominate technical-scientific discourse to reduce experiences into problems to be solved, depletes the richness of the breastfeeding mother's experience and can sever her experience from the embedded context of her life. An emphasis on problems rather than questions serves to distance all humans from our inherent interrelationships with the world. By extension, there is an added assumption that reality is ours to control. Burch continues "Our hubris is the conviction –sometimes tacit, sometimes boldly affirmed – that in principle nothing escapes our grasp, and hence that reality belongs more to us than we do to it." (p. 6).

The arrogance of this conviction can lead us to struggle against and approach reality as merely a problem to be over come. Yet problems and questions call for different means and seek different ends. Questions are concerned with issues that

directly link to our being in the world (Burch, 1986). The goal of questions is an ongoing exploration of self-understanding. Questions are not concerned with cognition and control. Rather they are concerned with 'the elucidation of meaning" (p. 7). Questions focus on who and how we are as human beings.

The technical-scientific discourse recasts life as a problem to be solved rather than a question to be lived. Problems focus on certainty, closure, cognition and control (Burch, 1986). Jardine (2000a) postulates that the difficulty of this focus is that technical-scientific language forecloses the possibility of questioning our own lives and our lives with children. When questioning is shut down, there are no possibilities for change or generativity.

Generativity has its roots in the Latin *generãe*, meaning to bring forth or produce. Jardine (2000a) uses the term to describe the creative possibilities for coming to new meanings and ways of thinking. Gelven (1989) describing Heidegger's philosophy of understanding stated "In short, our lives are meaningful not only because of what *is*, but also because of what *might have been* and what *might be*"(p. 76). Our questions allow us to explore the "might have been" and "might be" dimensions of the world. Without questioning and creativity, the next generation is doomed to become a dreary replication of all that is gone before. Further implications of the foreclosure of questioning will be discussed in more depth in a later section.

Questioning is also a requirement of ethical thought and behaviour. Bergum (1999) describes ethics as a never ending questioning and a process requiring dialogue, openness, contemplation and deliberation. This questioning can bring together disparate ethical approaches and viewpoints. The nurses' and the mothers' questions allow them to "see each other" (p. 177) and develop a fuller understanding of the situation and the people involved. The questioning brings legitimacy to the experiences of all involved. Questioning leads to the creation of an ethical/relational space where the focus is on "people (whole persons) and the quality of the commitments between them" (p.

Chaucer, in the fourteenth century, used the word commit to mean entrusting something to someone (Onions, 1966). The seventeenth century Latin word *committere* meant to engage or to place with another for safety (Onions). These historical meanings show that commitment is a relational word. All of these meanings highlight the trust in

another and the requisite strength of relationship that is associated with commitment. To commit is to engage with another and also to be comfortable to place something in safe keeping with them. The nurse's epitaph of what ever works in your house is a reflection of a deep commitment to the mother's experience and grounding. The nurse trusts that the mother with support will work out the best way to feed and parent her child. She engages with the mother to bring about this end. The Breastfeeding Centre becomes a safe place for the mothers to bring forth their personal stories. The mothers entrust the well being of themselves and their babes to the nurses.

In contrast it maybe useful to consider the language and inherent commitments of some hospital nursery staff, as evidenced by the following commonly heard statement "We let the mothers have their babies…". Their language speaks of their power and control in the hospital setting and to a skewed sense of possession and ownership of the children of other women. These nurses' commitments appear to be to themselves and the policies and the running of the hospital and not to the individual and particular experiences of the mothers and babes.

"Whatever works in your house" and "We let the mothers…" Two simple statements, yet two very different qualities of commitments brought forth. A one sided pronouncement such as "we let" does not lend itself to engagement or the questioning necessary for generativity or new ways of thinking. Whereas the statement "whatever works in your house" elicits further questions: What does work? How might this work in the future? What do you need to know to make this work? Questions assume a not knowing, can't know, don't know stance that pulls the relationship forward and requires a deep engagement with each other. The iterative process of the nurses and mothers questioning each other is an acknowledgement that understanding evolves from "not knowing" (Mitchell, 2007).

The mothers' questions direct the nurse and initiate the direction of the dialogue. The nurses' questions keep the dialogue open and focused on the mothers. The nurses initiate each new relationship and dialogue orientated to the mother and her experience in her own house and home. What does it mean to be oriented to house and home?

Orientation to House and Home

Home as Horizon

One's house and one's home refers to one's own place that is distinct from others. Home also speaks of one's beginnings and speaks of one's origins. For the nurses to be orientated to the mother's house is to speak of the mother's situatedness and her particularized, contingent and located knowledge and understandings. Her house and home reflects both how she comes to see the world and what she sees as important in the world. To speak of her house and home is to speak of the meanings that she has created from the context in which she has found herself. This context includes the discursive, material and social constituents of her life. Burch (1986) has described home as "the fundamental context of meaning we discover and sustain." p. 4.

Her house and home delineates the boundaries of what she can currently see. Her house and home act as a point of reference. Home speaks to the concrete contingencies of her life. Her home and her house are where she has started from and it will be the place to which she will return and the place where she will live after she leaves the Breastfeeding Centre. "Whatever works in your house" is an acknowledgement that the mother's life beyond the confines of the Centre takes precedent over anything that may occur there. Any recommendation the nurses might offer is necessarily linked but not limited to the boundary offered by the mother's home. The nurses' actions support the preservation of this unique person as she learns new things and grows as a mother.

The mother's house represents a starting horizon from which the mother views and encounters the world. Heidegger (1993) has described horizon (*horismos*) as a boundary - " the place you begin your essential unfolding from."(p. 356). We are historical beings – that is we are always standing in a situation and therefore cannot have a objective knowledge of the situation (Gadamer, 1999). Our homes and houses represent our history and our subjective starting point from which our understanding develops. Combining the ideas of Heidegger and Gadamer, human beings unfold from their historicality. Thus "knowledge of oneself can never be complete. All self-knowledge arises from what is historically pregiven … and hence both prescribes and limits every possibility for understanding any tradition whatsoever in its historical alterity." (Gadamer, 1999, p. 302).

"To acquire a horizon means that one learns to look beyond what is close at hand – not in order to look away from it but to see it better, within a larger whole and in truer proportion." (Gadamer, 1999, p. 305). Through dialogue between the mothers and nurses this horizon moves and shifts. The mother leaves her home and her grounding, going to the Breastfeeding Centre At the Centre in dialogue with the nurses, the horizons for each partner in this conversation shift ebb and flow like the tide on the beach – ever present and ever changing. As the mother learns and changes, her home horizon also moves and shifts. If her horizon at home has been influenced by the Babywise discourse, which serves to reduce the functioning of the home to a technical or mechanical response, the mother's dialogue with the nurses can enlarge her horizon and provide her with "the superior breadth of vision" (p. 305) that understanding requires. " 'To have a horizon' means not being limited to what is nearby but being able to see beyond it." (p. 305). Conversation and the interchange of questions opens the both the mothers' and nurses' vision beyond that which is nearby. The continual questioning carries the vision of both mothers and nurses outward into the beyond.

Home as Place

A house is both a place and a space. One's house and one's home refers to one's own place that is distinct from others. Houses and homes are places where we can be and are our best and worst selves. Our house and home is a place where we can be authentic and real. A place where no facades are required or appearances need to be kept up. Our house and home is a place to settle into and relax. For the nurses to speak of the mother's house is a declaration and commitment to the primacy of that contextual and situated place the mother comes from and returns to. Here the nurses acknowledge that the questioning and process of understanding starts with the mother and her experience. Just as the nurse in the Babywise vignette began with the mother and baby's current experience, the epitaph "whatever works in your house" orientates the nurse to the same starting point. For any meaningful conversation to begin, the specificity of the mother must be brought forward.

Home as Dwelling

The etymological roots of the word home are in the old German word *ham*, meaning dwelling or house (Onions, 1966). Heidegger's (1993) description of dwelling

as the basic character of humans is useful to broaden our understanding and acknowledge the interconnectedness that is foundational to humans living in the world. Heidegger links the Old High German word *bauen,* a verb that means to dwell, as well as the way humans inhabit the earth. Dwelling in this sense always precedes anything we might create or build. That is, we do not build in order to dwell, rather because we are dwellers, we build or create. *Bauen* also means to care for and protect, like one might cultivate a field and nourish a garden. Dwelling in this context has the sense of preserving and nurturing.

Heidegger links *bauen* with the Old Saxon word *wunian,* which means to stay in place and to be or remain at peace. The word peace means be free and protected and safeguarded from harm and danger. These actions may seem isolationist or bring to mind visions of a fortress cut off from the rest of the world. Yet is it a far more benign sense of safeguarding that Heidegger proposes. "To dwell, to be set at peace, means to remain at peace within the free, the preserve, the free sphere that safeguards each thing in its essence" (Heidegger, 1993, p. 351). Heidegger describes an open free space that allows humans to be what they are. Since dwelling is part of the essence of being, this free space is a necessary requirement for humans to flourish.

Heidegger goes on to describe the inconnectedness of humans as dwellers "on the earth" and "under the sky" and in connection with other mortals. Although we frequently speak of a human as a separate entity (e.g. the Enlightenment ideal of the 'rational man') who some how exists independently of the world, humans are in actuality inherently interconnected with each other and the earth (Jardine, 1998d). Thus fruitful human dwelling cannot be isolated from others and the natural world around us. It follows that our attempts to ignore these interconnections are to our individual and collective detriment.

Heidegger's view of dwelling as being brought to or remaining in peace and dwelling as the sparing or saving the sense of things so they can be what they are, is further elaborated by Devill & Sessions:

> Dwelling is not primarily inhabiting but taking care of and creating a space within which something comes into its own and flourishes.
> Dwelling is primarily saving, in the older sense of setting something free

> to become itself, what it essentially. … Dwelling is that which cares for things so that they essentially presence and come into their own (cited in (Jardine, 1998b, p. 112).

Heidegger's elucidation and further interpretation by Devill & Sessions of the word "dwelling" brings to mind multiple and rich images. These images speak of space of coming and becoming. The nurse's invocation of the primacy of the mother's home, her dwelling place, leads them both to the creation of a new space that is safe and nurturing. The act of being present and coming into one's own and flourishing is an act of creation. Birth itself is the ultimate act of creation. Motherhood and breastfeeding are a continuation of that creative endeavour.

Thus the nurse invoking "whatever works in your house" calls forth a world that is necessarily safe and nurturing – a place where all can dwell in peace and creativity can blossom. Although these nurse-mother-baby interactions do not take place in the mother's home – the essence of how one dwells in one's home is recreated at the Breastfeeding Centre. What kind of space is created at the Centre?

Breastfeeding Centre as a Homelike Space

Space is a physical as well as an experiential phenomenon. The physical space of the Centre is a large, bright room with windows running the length of an outside wall. The building where the Breastfeeding Centre is located is beside a park nestled under fifty foot pine trees. The building is old and resembles a well maintained 1950's cottage. As Pat laughingly described the building - "*Not medicalized, doesn't even feel like a government building, - maybe that because it's condemned!*"

Joan one of the nurses describes the setting and the participants.

> *We've had volunteers for years. One of the reasons they are there is they're loving and accepting, and they help the moms to feel comfortable They're grandmotherly, — we try to create an atmosphere there of "Welcome to my home." This isn't a clinical setting; this is a home and friendly setting. There's toys, there's activity going on, lots of bright pictures. But it's not a clinical place; it's a home place...I will say, people who come there are people who are having problems, so they're coming in with some emotional distress. They're worried about their baby; I mean,*

there's a really kind of negative mindset that they're coming in with, and stress. And if we can create that atmosphere that's warm and welcoming and home-like, casual, relaxed, non-clinical, then they're going to relax, they're going to be able to articulate better what's happening with them. And what we do, we have the volunteer go and meet them; I love our volunteers! They are so wonderful! And they welcome the ladies in, they weigh the babies, help them to feel relaxed.

The ambiance of the setting is one that beckons. The processes and procedures used in the Centre are attentive to the mothers' and fathers' anxieties and vulnerabilities in coming to the Breastfeeding Centre. Thus the physical space has been designed to calm and sooth. The human participants are intent are on creating a space that sets the scene for a positive encounter and for the beginning of an engaged relationship. The mothers' first encounter is usually with the volunteers. The volunteers are motherly figures emanating nurturance and warmth. The home like setting of the Breastfeeding Centre demonstrates the nurses' attunement to the mother's home. The effort is to replicate elements of the homes the mothers have left and to avoid a cool, sterile, clinic atmosphere.

Below are two mothers' descriptions of their first encounters at the Breastfeeding Centre. The mothers' comfort in the homelike space is evident.

A mother describes her first experience at the Centre.

So it was my first time there. I felt comfortable immediately when I walked in, 'cause obviously, they welcome you. They basically just explained how things were going to happen, what we could do. It was just a nice process; you just felt like you were going to get things taken care of and your issues resolved. They were attentive, well-organized, and obviously experienced, and made me feel comfortable..

Sally described her experience:

It was comfortable. It was very — like I felt if I needed to just call, or if I needed to go down there, they would always be like- that was fine, whatever it was. It was very kind of [pause] sort of a safe place, you know. As I said, it was casual— very friendly. It was all positive.

The experiential space described by these mothers was in line with the intent that directed the nurses' work. The nurses all spoke of their intent to create a warm, welcoming and safe space for the mothers and babies. Pat described the environment in the following way.

> *I would want it to be a safe, nurturing environment for them, a place to debrief. I think that's a big piece, a place to feel comfortable to ask any questions, a place to check out any questions, a place of trust, and a place of continuity, because so much of the debriefing is dealing with the inconsistency and the frustrations of the mother's experience with conflicting breastfeeding information.*

Space to Open

Space speaks to an "opening up". Heidegger described a space as " something that is made room for, something that has been freed, within a boundary, the Greek *paras*. A boundary is not that at which something stops but, as the Greeks recognized, the boundary, is that from which something *begins its essential unfolding*." (1993, p. 356). The mothers' homes are the boundary from which they begin to become themselves as mothers. The term unfolding speaks to something that was small and turned in on itself, becoming larger and more vast, more open to the world. Ideally motherhood is not restricted to the confines of a folded, crapped space such as Babywise or other restrictive discourses offer mothers. Using Heidegger's perspective on boundaries and space, things are allowed to become what they are. Applied to motherhood, given space mothers can become all that they can be without arbitrary restrictions on their becoming.

However this becoming is not the fictional autonomous becoming promoted by our consumer society (Smith, 1999b). In the consumer world, becoming is reduced to "be the best you can be", a slogan redolent with the myths of "individuality" and of "choice" Ironically the outcome of these myths is a cultural homogenization and sameness. The resultant world is one that is folded in upon its self. It is a world where individuals associate their "being" and their identities with their possessions and their difference (separateness) from others. In actuality we are inherently interconnected and our becoming is contingent on our relationships.

The becoming that Heidegger speaks to unfolds in relationship to others. The very existence of a mother is dependent on the existence of a child, just as the child is dependent on its mother for its existence. One cannot become a mother without a child and a child is not born without a mother to carry the child as fetus during pregnancy. The child and mother are inextricably connected to the natural world around them. The becoming that Heidegger describes acknowledges the deep interconnection of individual, and community and the earth.

Maturana,Verden-Zeller, & Opt's (1996) definition of love evokes another understanding of space and opening up or making room. The definition demands us to think of space and relationship as an active creative force. They defined "love as making space for the existence of another." The definition implies that we can make space – we can open and make more room. Space is not a concrete formed constant but rather it can change and enlarge. Love involves the activity of enlarging space and making room. This definition speaks of an engaged, vibrant process – and of strong commitment to another. We do not just passively love someone. To love someone, we must actively make space. The act of making space is our declaration of love and our gift to those we love. In above definition, humans are asked to commit to and respect the other in the fullness of their being – their whole existence. Making space means welcoming all components of the other and a refusal to deny any dimensions. Just as the mother makes room for a new child in her life, the nurses create space for mothers and their experiences. Sally said during her interview when the baby was three months " *You know, initially we were kinda weird with anxiety, but it was always okay, whatever we asked or did."*

In the following excerpt the mother describes her relationship with the lactation consultant. Although she uses the word friendship rather than love, there is the same idea that friendship involves the making of space for another. Derrida, as paraphrased by Caputo (2000) said " a friend is found more in the activity of loving , than the passivity of being loved" (p. 78).

> *I think of Pat as almost a friend now. She's just — she's the kind of person where I bring Sarah in every month, just so Pat can see her. You know, so she can see the success of breastfeeding with Sarah, and she was part of that success. I really feel like she is a part of Sarah [pause] being so*

healthy, and us being able to breastfeed and continue breastfeeding,. That's probably how I would describe that relationship. Just for support. She's very supportive. Like, she's very easy to talk to, and you know [pause], the same things as I would find in other friends, you know, where she just has been very supportive and non-judgmental and — there for me. She was there when we were having a really hard time, and she made it easier. It was with her help that it got easier and better and, you know she's probably not a friend in the sense that I would call her up to go to a movie [both laugh], stuff like that, but you know, she has become a part of our lives since Sarah's been born.

To become a part of another's life involves the making of space and commitment to another. This willingness to make space can be labeled friendship as in the above quote or as in the nurse quotation below it may be labeled love. In each it is a relationship that requires something of the other. Although the above mother uses a term that may cause an outsider to question the professionalism of the nurse, the mother is very clear of the boundaries of her unique friendship with her nurse. As she notes the nurse was not "someone to go to movies with" but someone like a friend who cared, supported and made things easier. "A friend is someone that supports us perhaps in a way that is very close and intimate." (James, 1997, p. 170). "Friendship" in this acknowledges the closeness and willingness to "make space" and accept the other.

Joan's reflection upon her colleagues and why she enjoys her work so much demonstrates the willingness of the nurses to actively make space in their lives for the existence of the lives of the mothers:

every single nurse who works there feels exactly as I do. You know, there's that enthusiasm about breastfeeding, there's that love of the moms. And there has to be that kind of love and respect and acceptance, because moms of all shapes and sizes and philosophies and whatever come in there. There has to be unconditional acceptance and love of them. And I use the word love just because [pause] I think —— you have to really — you have to care about them. You can't be detached and clinical.

Breaking down Maturana, Verden-Zeller & Opt's definition further, to make is to create and creation speaks of something new and full of possibility. Possibility is the idea that "things can become something other than they have already become" (D. W. Jardine, 2000a, p. 115). Possibility speaks of change, growth and generativity. In creating a space for another's existence, nothing is foreclosed nor predetermined. Possibility is closely aligned with hope. When all possibilities are lost so is our hope for the future. Thus the definition of love as space is essentially open and hopeful. It allows things to become what they will become.

Yet how do things become other than they are? How do we act not just to conserve but also to generate? That is to bring new ideas, thinking, and actions into the world. Generativity is immediately concerned with the ambiguous and uncertain nature of life. Generation presupposes questioning of what has gone before. Jardine (2000a) describes the essential generativity of life, " a sense of life in which there is always something left to say, with all the difficulty, risk, and ambiguity that such generativity entails." (p. 120).

Discourses that act to have the final word and shut down discussion work against generativity. The discourses circulating in Ezzo's method act in this manner with detrimental consequences. Yet to let discourses such as this gain ascendancy is an act of abandonment. "And if we abandon our care for and devotion to the conditions of generativity, we abandon our care for and devotion to our children." (D. W. Jardine, 2000b, p. 21). In contrast, the space created at the Breastfeeding Centre is a declaration of care and devotion to children and their parents. The Breastfeeding Centre space honors hope and engenders generativity and creativity.

Relational Space

Questioning presupposes the ambiguity and uncertainty of life that fosters generativity. As discussed earlier, questioning can lead to the creation of a relational space. The space of the Centre allows the mothers and babies to dwell safely and peacefully in their new experience. The nurses and mothers together create a relational space. Bergum & Dossetor (2005) describe such as space as being non-dualistic and non-hierarchal. In this space a mother's home and all the meanings that emanate for the woman from that space are not seen as separate or lesser than the meanings the nurses

bring forward at the Breastfeeding Centre. Both mothers and nurses are open to the experiences of the other. The mothers' and nurses' questions do not compete nor dominate but rather complement the ongoing conversations.

Further in a relational space the particularities of individuals are not isolated from the needs of the larger community and the world (Bergum & Dosseter, 2005). Other relationships beyond the nurse-mother relation require consideration.

> *Certainly the doctor is a huge influence. I always make a point of saying, "Who's your doctor?" and "What sort of relationship do you have with your doctor?" and "Do you feel they're supportive?" and that kind of thing, just to get a feedback of what you might be dealing with. I never try and say, "Your doctor's wrong," 'cause I think it's very important to work as a team, and as soon as you sort of label, right away you're closing some doors.*

Relational space requires that voices outside the relationship be considered and brought into the space. This nurse acknowledges the need to keep the doors open and the space as expansive as possible.

Individuals, although autonomous, are also interdependent. The nurses have the individual mother in the foreground of their work and thoughts, but the larger context of their work is not forgotten. The nurses saw their role extending beyond breastfeeding assistance to contributing to the development of a better world. One nurse described her work in the following way:

> *Really, the bottom line is if we want to have a healthy, happy peaceful society, we have to foster those loving, positive relationships. They happen first in the home. I don't care if just mom and babe or a huge extended family, or whatever, that's the foundation of society, and I think (chuckles) breastfeeding can support that! And it doesn't have to be breastfeeding; really, what is important, is positive maternal-child and paternal-child relationships and that's what we're trying to do.*

How does the work of a nurse change when a nurse simply believes she is assisting someone to breastfeed, versus believing she is helping parents develop positive relationships with their children so the world becomes a better place? The emphasis on

what is most important shifts from the outcome (e.g. successful breastfeeding) to the process and the ever-unfolding mother-child relationship. The emphasis of the interaction shifts from problem to question and to a more expansive vision of the world. Focusing on the individual as well as the contribution the individual mother and babe can make to the larger community frees both the nurses and mothers from an emphasis on prescription. The nurses' vision of breastfeeding broadened to a vision of positive parenting, opened the space of their practice beyond success at exclusive breastfeeding and recognition of the inherent interconnected nature of human beings.

Creation of a Hermeneutic Space

The space created by the mothers and the nurses at the Breastfeeding Centre can also be seen as a hermeneutic space. A hermeneutic space is one where meaning is explored and where the world can be interpreted anew. It is a space where neither meaning nor outcome is predetermined. A space where there are no absolutes. Nurse Betty described the practice – "*it's a constant evolution, because the parents are changing their perception of things as they go along and you try your best to work with the parents*"

A mother described the changing circumstances that brought her back to the Breastfeeding Centre:

> *I'd gone the first time thinking, "Okay, I'm going to get this fixed, I'm going to figure out what to do, and I've got it all." You know, you don't have to tell me twice, right? But I ended up going back, I think, three or four times,— in total — because there was always something else that came up, you know, at different stages, or whatever, or something I didn't quite know about, like, gas, for instance*

A hermeneutic space is one where the temporality of meaning (Caputo, 1987) is respected. There is acknowledgement that meaning is not static and unchanging. Derrida described writing as having an 'essential drift.' (as cited in Giddens, 1979). Derrida's comment refers to the multiplicity of meanings that arise when others interpret a text. Similarly in the hermeneutic space of the Centre there is no one meaning for a situation, only meanings. Because there are multiple participants in the space of the Breastfeeding Centre, multiple meanings arise, change and drift from their starting point. This makes a

hermeneutic space inherently a productive space when meanings can be reinterpreted, generated and transformed.

It is a space where there is a " postmodern commitment to motility of meaning" (Smith, 1999c, p. 122). Yet is not a space 'where everything is relative'. Nor is it a space without other commitments. In fact, it is a space where it is accepted that "the meaning of anything is never knowable purely in and of itself, but only in so far as it bears a relationship to something, or to others." (p. 122). In this respect it is an intensely relational space where the 'facts', one's experience and its meaning cannot be separated from the actions of the individual, society and the world. Betty, an nurse, alluding to a false and gross reduction of the breastfeeding experience, said " *So it's not just a baby, a weight, and how much the intake is.* " A hermeneutic space acknowledges the presence of the world is already and always present and prior to our lives and our experiences (Smith).

A hermeneutic space is one where is it accepted that the world and its meanings cannot be understood in an arbitrary way. Thus "*the hermeneutical task becomes itself a questioning of things* " (Gadamer, 1999, p. 269) author italics. The questions are not just nurse to mother and mother to nurse. The nurse questions herself and her practice. She asks "*What is happening here?*" and sometimes has to say "*You know what? What I said earlier isn't working. We got to try something else.* "

Whatever Works in Your House is a tacit acknowledgement of one example of the presence of the world in the mothers' lives before, during and after their attendance at the centre. In the hermeneutic space, exploration proceeds from the assumption that the world is already there and attempts to explore ways to live with this present dynamic world (Smith, 1999b). This is in contrast to discourses such as Ezzo's , which challenges the world as it presents and attempts to mold the world to fit their desired conceptualization. In a hermeneutic space the world "is enterable, full of portals and ways" (D. Jardine, 2000, p. 175). These portals and doorways are there for the mothers to discover and explore. For discourses such as Ezzo the only door to enter the world is the door that Ezzo will open for you and the only path to follow is Ezzo's way.

The world created by the nurses and the mothers is more difficult, more ambigious and more ongoing than the world Ezzo and his ilk offer. The Breastfeeding

Centre world is also more pleasurable, more engaging, more sustaining and more nourishing than anything Ezzo might allow.

How does this differ from Ezzo? Ezzo has predetermined the parameters and proper passage through the experience of breastfeeding and parenting. It's a view that is underpinned by a desire to get to the other side, to move beyond the present moment and arrive quickly at the faraway desired state of the obedient child. Perhaps it would be better worded as an attempt to bypass the experience – just as a highway bypass offer a route around a city to save us time and effort on our way to somewhere else, the Ezzo prescription offers the promise of a way around or quickly through breastfeeding and motherhood. Yet driving the ring road around Edmonton, without stopping and authentically engaging with Edmonton citizens, does not allow to one say they have lived in or know Edmonton. Similarly the purported fast passage that the Ezzo method offers keeps parents removed from the actual experience of engaging with a child in a fully aware and responsive interaction.

The nurses accept there is no quick passage through or around motherhood and breastfeeding. They propose no bypass around this experience. Instead they wade into the midst of the mother's experience. The outwardly repetitious questions that the nurses ask become a means to journey for a while into the mother's experience. Questions such as "What's going on for you now?" "How much is he feeding?" "How often is she wetting her diaper?" "Does it hurt when she latches?" "How are you feeling about this?" serve to draw the nurses closer to the experience of the mothers. It is through questioning that the hermeneutic space at the Breastfeeding Centre grows. The nurses' questions acknowledge mothers have a range of experiences. That nothing is abnormal or verboten. The questions imply that breastfeeding isn't easy, natural and a cookie cutter experience for every mother. The nurses acknowledge and attend to the incomparable experience of *what is*. "And you already know that motherhood is not like anything else." (Maezen Miller, 2006, p. 40)

A hermeneutic space acknowledges that the world is "interpretable" and not already interpreted. "Such a world is open to being understood otherwise, to *becoming* otherwise."(Smith, 1999e) A hermeneutic space is therefore a space that is open to the "play of possibilities inherent in the heart of life" (Smith, 1999c, p. 122). There is no

need to impose "punitive (wishing things were others than what they are)" (p. 122) judgments on human actions. In a hermeneutic space prescription and admonishment are antithetical responses to individuals responding to the difficulties and complexities of life. Instead, an interpretable space is one that supports the flourishing of generativity and growth.

A hermeneutic space must to be spacious in order to embrace motility of meaning and the presence of the world as it is. The term spaciousness is used to describe an area that can hold much. What is accommodated in the hermeneutic space created by the nurses and mothers at the Breastfeeding Centre? What movement is allowed?

Space for Heterogenity and Difference

At the Breastfeeding Centre there is sufficient space to hold divergence and difference. At the Centre there are not good mothers and bad mothers, successful mothers and unsuccessful mothers. There are only mothers, similar yet different. There are mothers who become fulltime parents and breastfeed for three years and mothers who go back to work at one month postpartum. There are mothers who no longer breastfeed but come to weigh their babies. There are mothers from all income groups – teen mothers on social assistance, immigrant mothers and thirty something educated professionals with graduate degrees. They come together and are united in their desire to breastfeed and parent well.

This ability to attract and serve a broad range of mothers is largely due to the service being free and publicly funded. In many locations in Canada, the services of lactation consultants are not covered by public or private health care plans. Therefore only those who can afford to pay have access. That the Kelowna Breastfeeding Centre space exists speaks to the role of political and economic discourses in shaping all our lives. Breastfeeding and its support or lack of support takes place in the political world of health care funding amidst stiff competition for scarce resources. All mothers who deliver in the Kelowna region are seen at home by a maternity care nurse within forty-eight hours of their discharge from hospital. At this home visit they are told of the availability of the Breastfeeding Centre service and are either referred immediately (for those having problems) or encouraged to phone or attend should a breastfeeding problem arise. The easy accessibility, which is a direct result of health care administrators

economic and political decisions, is a key reason for the heterogeneity and diversity of mothers seen.

This publicly funded space was designed to accommodate all and to be a space to move and grow. The approach of the nurses at the Breastfeeding Centre starts where the mothers are and then moves to address their desired vision. In this movement there is space for joy, sorrow, laughter, frustration and grief. For Erica there was joy that her nipples no longer hurt and she could feed without a nipple shield. Shirley experienced grief that despite her great efforts to increase her milk supply, supplementation was required to adequately feed her son. Janet was sad that she had no help in her attempts to breastfeed her older children and also experienced great happiness that with assistance, she was able successfully breastfeed her third child. There was shared laughter as a mother described sitting in a busy coffee shop while trying open the container with her nipple shield, keep her breast covered and hold a frantically hungry baby. All the nurses experienced frustration that there are no resources for mothers with postpartum depression and these mothers' needs were beyond what can be provided at the Breastfeeding Centre.

Acknowledging Heterogeneity and Difference

Just as the Breastfeeding Centre service welcomes all mothers, the nurses in their practice acknowledge heterogeneity and difference that exists. There is recognition by the nurses that breastfeeding is not a homogenous experience. As such the nurses do not attempt to enforce homogeneity or to eradicate difference. There is no reduction to "the economy of the Same" (Irigaray, 1985, p. 117). The hermeneutic space created at the Breastfeeding Centre is large enough to hold a multitude of desires, needs and experiences. There is no predetermined or prescribed outcome that must be met.

The nurses acknowledge the distinctness of each mother's experience. The nurses demonstrate a fealty, a faithfulness and loyalty to the mothers' actual desires and wants. Gwen described her initial meeting with a new mother in the following way:

> *When they come in, I always like to figure out, "Is this your first baby? Have you had past experience breastfeeding? How old is this baby? What are your goals? Do you plan on exclusively breastfeeding this baby, or do you just want to be able to do it at nighttime for nuzzling to put him to*

sleep? What do you want to do? What do you want me to do for you? Do you want me to teach you how to exclusively breastfeed this baby, or do you want to be able to do both? What's going to work for you in your house?" I think the more skilled you become as an LC, the more you'll be able to adapt to their needs and look at their plan, not your own agenda. I think that's trust. It's not kind of, you know, coming in from the side and taking over. It's important to meet them where their needs are.

The nurses acknowledge that it is possible to inundate the mother with too much information and too many plans of actions. This sensitivity to the mothers and the nurses' intention not to overwhelm with their knowledge under the guise of helpfulness, builds trust and strengthens the relationship. The nurses trust and believe that the mothers want the best for their infants. They trust that given support and appropriate information, the mothers will find the best way to give to their particular child and respond to their child's uniqueness. The nurses' trust in the mother engenders her trust in the nurses. This trust in the mothers is indicative of the nurses' respect for the mother's desires and thoughts is a reflective of the deep respect extended to the mothers.

The respect that the mothers and nurses share does not serve to distance them as a Kantian view of respect would demand (Dillon, 1992). Rather respect is interlinked with caring in a "more integrative approach" (p. 107) to respect and to care. Respect has dimensions of attitude, conduct and valuing. A respectful attitude is one of attention and concern. Dillon states "So *attention* is a central aspect of respect: we respect something by paying careful attention to it and taking it seriously" (p. 108). The nurses' Whatever Works in Your House orientation directs them to pay careful attention to the mother's experience. Conduct includes our response to that which is respected and that nature of our response varies according to that which is respected. In this instance mothers and nurses are respected and valued for their own inherent worth as individuals and as "the whole and concretely particular person she is" (p. 117.). There is respect for both their personhood and for their individuality.

The following words of a nurse capture both the respect for mothers as persons and as individuals;

I think that's very important, because I think for each mother and for each family or house, their definition of what and how much and how long and how they're going to breastfeed is going to vary per house. Even though we have the overall "ace the exam, get 100 percent, perfect idea" of how these moms should breastfeed ideally, in each house, they're going to do their own thing, whether they're pumping-bottling, where they're doing exclusive breastfeeding ad lib, whether they think they're going to be able to schedule these kids on the breast, or different ideas for home or out in the community when they're out with their babies. I think that is key. I think that you need to be able to respect — they're the expert; they're with this kid 24-7; we are just the facilitator so to speak, of the knowledge to help them meet their goals that they've defined what they want to do. I think it's huge. They aren't a population that you can say, "You have to do this, this, or this." To a certain extent, and some things, you have to say, "You need to get a proper latch or you're going to have cracked nipples and you're going to run down this runny slope." So giving them the tools of what has to be done mechanically or technically proper or perfect, and building that trust, then, to give them those skills, so that they can take their breastfeeding experience to however they want to do it, I think, is huge.

Mother's perspective

they (the nurses*) live their philosophy so vehemently. They really, really do. They believe that the very best thing that you can do for your baby is to breastfeed. If you can't, I mean, there's no push, there's no pressure. Any woman that goes in there and isn't breastfeeding and goes for a different reason is supported, but if you're like me and really want to do it, they're just so supportive of you and answering your questions and cheering you on with your little successes, and ignoring the things that don't work! Its like they'll do anything to make your experience positive if it's possible.*

Second Mother's perspective

> *I think because we went so much, it got kind of friendly, and I definitely had a lot of respect for them. I mean, being a lactation consultant seems to be such a science, and, they need, like, a million hours (of practice) just to write the exam.*

The above nurse and mother excerpts refer to the deep respect that the nurses offer to their patients and the respect that is given in return. Bergum & Dossetor (2005) note that "*respect for one another* is an essential aspect of a relational ethic" p. 67 (italics theirs). The above nurse and mother excerpts indicate the mutual nature of respect – the mother clearly respects the nurses' skills and support and in turn the nurses respect the primacy of the mother's experience in guiding the course of care.

Bergum & Dossetor (2005) go on to describe the etymological roots of respect and identify the need to be actively attentive and willing to 'look again' to truly see each other. The nurse's words about the mothers, "they are the expert", acknowledges that knowledge does not reside only with the nurse, but also that the mother is a rich and important knowledge source.

> *I'll never forget a baby visit I did once. It was a baby visit I did with an Asian family. They were sitting on a straw mat on the middle of the floor in the apartment. I think there was an grandma there, and a couple of little kids, the dad, and everybody, and everybody's sitting cross-legged on the floor, so I got down and I cross-legged on the floor on this mat. And the mom was breastfeeding a newborn, sitting almost upright, and the kid was kind of hanging on the end of the breast. I thought, "Oh, my goodness, this is not a good position [laughs] for a newborn." But I asked her how she was doing, and we weighed the baby; baby was gaining fine. So, it definitely worked for her. So I often think, "If it's working for the mom and babe, leave it alone; don't touch it."*

The nurse demonstrated her respect of the family's culture by joining them on the floor and interacting with them in their customary cross-legged position. The family was not asked to adapt to the nurse. Rather the nurse adapted to the family and their house and home. The breastfeeding position described by the

mother went against every textbook description of proper positioning at the breast to prevent problems. Yet the nurse "looked again" and saw the mother and babe were thriving and found no need to conform to some outside standard.

Whatever Works in Your House is an implicit acknowledgement of respect and of heterogeneity and difference. The nurses' acknowledgement that there are many paths to successfully parenting is a movement away from absolutes and certainty. This movement frees both mothers and nurses to pay careful attention to each other and to take each other more seriously than any discourse or societal troupe. Betty, an experienced Lactation Consultant reflected upon the work of the Breastfeeding Centre nurses and said " *I think one of the biggest things that we can do as nurses at the Breastfeeding Centre is not equate exclusive breastfeeding to being a good parent and helping the parents realize it's so much more than that.*"

Striving for Connection and Meaning

The nurses were drawn and found deep meaning and fulfillment in working with new parents. This section begins with the nurses' reflections upon their choice of work. Evident in each reflection is the importance of relationship and the implications for practice when relationship and connection were brought to the forefront. One nurse spoke of her experience as a student of working with breastfeeding mothers and how the closeness of the relationship and contribution you could make drew her to the work after graduation.

> *So that kind of reeled me into that one-on-one piece with them, and how beneficial that was and what an impact you could make.*

Another identified the type of relationships that Public Health work engendered with patients, made it her preferred area to work.

> *Hospital nursing has never interested me. I knew that wasn't an area I would want to work. I don't know it just was never something that had thrilled me. It was always far more the teaching, and the sort of relationship end of it that I enjoyed.*

Another described a professor who taught her during her degree program.

> *My class was very connected with her and we were around when she was having her babies, and she scheduled her work time so she could*

breastfeed her babies. This had a huge impact on my class and interestingly, a huge proportion of us have ended up in public health.

Meaning for the above nurse and her fellow students grew out of connection for this instructor. The deep connection of the professor with her nursing students paralleled the deep connection the Breastfeeding Centre nurses strove to have with the mothers.

The fourth nurse had a personal experience of a family member not receiving the support they needed to successfully breastfeed.

I had this underlying desire to help my sister, who went on to have her second baby and never breastfed, who has since gone on and is an LC herself.

For each nurse, their chosen field of nursing practice arose from connection – either having a relationship with a breastfeeding woman (sister, professor) or the pleasure that the opportunity and ability to develop a meaningful relationship brought to their practice. The desire for connection brought the nurses to the work of lactation consulting. Not surprisingly the ability to connect was viewed as a baseline job requirement.

I think one of the things to be a good public health nurse; you have to be able to engage with people. You can't be detached; it doesn't work in public health.

How do the nurses strive to bring about connection and relationship?

A nurse's view.

Yeah, a positive, warm, welcoming atmosphere, where people are valued as individuals, and where — sometimes it's very hectic, and you move from mom to mom, but when you're with that mom, hopefully, she feels that she has your attention, your undivided attention.

A second nurse's perspective

I think there's very much a listening, but there's also a clarifying. Like there's an interaction that happens where they feel that they're in charge. I think in the Breastfeeding Centre that's really important, they know what they want and its our skill that helps to tease that out and keep clarifying it with them,.. they know what they want but maybe its not clarified yet in

their head, so its reflective listening, and then kind of throwing things out, ideas, wondering, but never taking charge, or being in control.

Mother's perspective

They really listen. They listen to exactly what you're saying, and they ask open-ended questions that encourage you to really talk about what your issues are. You're not feeling like a failure because things haven't worked; you can really just open up and tell them everything. I think that's what made it successful for me, because they resolved my issues that I had at the time. Whatever I forgot, of course, I went back the next week or the following week, and, "What about this?" and "What about that?" So it was just really good.

The importance of listening was central in each of the above quotations. Listening validates the experiences of the participants and takes the conversation deeper. The act of listening connects the sensory acts of speech and hearing, drawing them close. The act of listening also draws the partners in the dialogue towards one another involving them in a new co-creation. "When we are listened to, it creates us, makes us unfold and expand. Ideas actually begin to grow within us and come to life. It makes people happy and free when they are listened to" (Ueland, 1992, p. 104). Ueland identified the power and energy that listening can draw forth. The power of listening is in the energy it creates for transformation, generativity and growth.

The mothers come knowing what's important for them, what must be held on to and what they are willing to let go. It may not yet be made explicit nor may they be not able to label it. But through the conversation with the nurse, a vision of what they would like to happen in with their child and with their breastfeeding begins to unfold. They may not yet know how that will happen or could happen. Yet the nurses reach forward with the mother by listening and in conversation to discover and elaborate that vision. Using the words of Susan Griffin (1999), the nurses have "the ability to detect a vaster landscape at the edges of her story" p. 46. The nurses are very aware that there is always more that they don't know. Because they can't know in advance what vision the mother is seeking and what assistance the mother needs, the nurses "not knowing" leads them to seek further.

They are aware there is always more to know beyond their present understanding of the mothers. Arendt (1994) states "Understanding is unending and therefore cannot produce final results" p. 308. The above mother's description reflects this open and never ending search for understanding. What was understood last week might not be what is understood this current week. So the nurses and mothers question and seek. The ongoing questioning widens their perspective on their interactions and their relationships.

The hermeneutic space is a space where connection is sought.

Nurse Pat on connection

> *I guess it's all in the approach. And I think they really want that connectedness with you, that eye contact. They never leave you. When you talk to them, that eye contact is right there. And if you can engage them, you get more pieces and you get more in depth, and I think that there's that trust and there is the respect for what their experiencing.*

Mother on connection

> *With my mastitis, the doctor told me the same thing that Pat said but then I don't know (pause)... It must be the way - how he said it to me. I just felt like " Yeah, I know that." You know it just went by, I don't know it didn't really connect. Whereas where Pat said it to me and then the next day again because I was still not getting it because I was feeling so sick from the mastitis - I don't know I guess I'm just really interested in what she has to say. When Pat says something (pause) ... it has deeper meaning for me.... I think that's because of the relationship we have.*

Both nurse and mother acknowledge the intertwining of connection and relationship taking the conversation deeper and making the conversation more respectful. The etymological roots of the word connection are in the Latin *connectere* , a combination of con (with) and *nectere* (bind, fasten). The mothers and nurses together forge a link that assists and supports them in their mutual search for understanding. The drawing together of perspectives through connection results in a stronger (more likely to withstand difficulty) and more meaningful (more likely to result in understanding) outcomes than individual perspectives alone can supply. Perhaps the doctor's words

failed to resonant with the above mother because her story did not resonant with him. The perspectives of both the doctor and mother remained separate with no point of connection or commonality to draw them together.

This type of connection involves a broader picture of the concept of autonomy. Connection brings about an increasing knowledge of self and the other learned through relationship and dialogue. "Autonomy, as relational is one in which the distinction between people is less defined, less definite and less distant."(Bergum, 1999, p. 172)

Attunement to Deeper Meaning

Attunement to deeper meaning is both precursor to and an outcome of connection. The following excerpt from the mother of a premature baby vividly outlines the importance of the nurses' awareness of the deep meaning breastfeeding held for her.

> *The biggest thing for me and for every mother but for me in particular, the pressure to get it right, do something right. You know, I still get very emotional talking about this, so you'll have to excuse me, but I feel guilty for a lot of what had happened to me. [sobbing] So yeah, and I firmly can say now how stupid it is that I feel that a lot of what went wrong is my fault. But then it was so important for me then — to do something that real mommies do, you know. You want to — I wasn't able to give birth, I wasn't able to hold him full-term, and I saw him nearly die [sobbing], and my nursing was a way of getting some of that back. So yeah, I placed a great deal of importance on it, and they understood — and not just Betty but all the nurses there, they understood that. I don't think I ever said that to them, but I felt that — they understood how important it was to me- to us. I never felt I was bothering them. I went a lot [both laugh], a lot more than a lot of women who might just go a couple of times and get it right and then go away. But yeah, I used it as a support, just as a support for myself, and it was really good. The first few weeks when my husband was away I really didn't have anyone to talk to.....*

Attunement to deeper meaning took the relationship beyond a general acceptance and a nonjudgmental stance. The nurses' understanding of the depth and intensity of this mother's emotions and desire to breastfeed created a space where she could move beyond

her unfounded guilt around the circumstances of her child's premature birth. The Breastfeeding Centre was a place to be her self and to be accepted for all that she was. It was a safe place where anything was said and asked. As a mother reported in an earlier quotation it was a place that no matter what your circumstances *"you don't feel like a failure"*.

The theologian Henri Nouwen (1975) said "As healers we have to receive the story of our fellow human beings with a compassionate heart, a heart that does not judge or condemn but recognizes how the stranger's story connects with our own." (p. 96-97). Compassionate listening and attunement to deeper meaning allowed the nurses to see the mothers' suffering and vulnerability. The nurses' implicit recognition that every mother's suffering and vulnerability was a human trait rather than an individual shortcoming, allowed a nonjudgmental space for new possibilities to happen. Attunement to and acknowledgement of the deeper meaning of the mother's experience allowed her to move and become more than her story of difficulty and suffering.

Seeing their Personal Stories in the Larger World

The hermeneutic space of the Breastfeeding Centre, that fostered interpretation and reinterpretation, created a "world of hope and optimism despite present difficulties" (Davey, 1990, p. 273). The difficulties of life are ever present. The nurses' compassionate listening and acceptance shone a new light on the mother's concerns and offered hope and possibility that *"this will pass"* and *"things will get better."* The nurses' acceptance let the mothers know they were not alone – that all mothers struggle. Just as nurses' Whatever Works in Your House orientation is carefully attuned to the mother's particularity and individuality, the nurses at the same time are also attuned to the universal nature of the problems of motherhood.

Motherhood and breastfeeding are often viewed through a gauzy lens of romantic ideals (Maezen Miller, 2006; Maushart, 1999; Steinberg, 2005). Maushart (1999) described the situation:

> No matter what the cultural setting, a woman's preparation for parenthood will inevitably prove partial and imperfect. Yet in our own society, the evidence suggests, we increasingly bring to the experience expectations that are not simply

> inaccurate, or ill-informed, but downright disabling. Mavbe even delusional (p. xiii).

Maezen Miller (2006) describes the disabling and possibly delusional expectations that she and her friend held:

> Underlying our friendship was the sense, the certain fear, that all around us were better mothers, who were thin and groomed, confident and competent. These mothers had resolved all the questions about feeding and sleep, poop and potty training, preschool and playmates, teething and talking, paper or plastic, that kept us forever unsteady. They were mothers with a method. They were doing all the right things. They were on all the right waiting lists. They could shower, style their hair and dress in their cute prepregnancy clothes every day before breakfast.
>
> ....
>
> They had birthed not just a child but a fully formed ideology of parenthood. It made things look easy and it made things look right. (p. 4)

Motherhood discourses about the correctness and ease of motherhood serve to isolate new mothers in their insecurities. New mothers believe that they alone are struggling and everyone else is getting it right. In their vulnerable, sleep deprived state they believe the romantic ideals. Rather than question the ideals; they question themselves. "To have a child is to put oneself in question--involving inner change in a woman's understanding of herself" (Bergum, 1997, p. 139). For new mothers "must shed the skin of your old individual self and grow a new one with enough room for this small person-who-isn't-quite-an-individual yet" (Barrett as cited in Maushart, 1999, p. 113).

The initial questions of new mothers often cause them to doubt their basic capabilities. Guilt is the most frequent consequence of the skin shedding described above (Maushart, 1999). The everyday difficulties of parenting become conflated with a sense of not being good enough and of failing their child. They feel guilt because they desperately want sleep and time for themselves when their babies' vulnerability and helplessness seems to require their selfless devotion. This guilt is compounded by persistence escalating cultural expectations of the performance of mothers. This, not surprisingly leads to increased perceptions of guilt and inadequacy (Dally, 1982).

The nurses acknowledge the contradictions in the experiences of breastfeeding and mothering. As they draw forth the mothers' personal stories, they reassure and place the mothers' stories in the larger context of the world. They acknowledge that the motherhood stories of struggle and difficulty are universal and not personal.

A mother reflected.

I just felt very comfortable with her. She's just very "Don't worry about it. You're not the only one that's been through this" — you know, that kind of thing. So very — reassuring. She said, "It takes a while. Don't get frustrated, just kind of give it your best. " She was very not pushy, she was just kind of "It is a benefit to your baby. We're there to help you.

The nurses' responses say to the mother *"Yes that happens – you are not alone"*. When mothers describe an experience or are struggling to latch or have flat nipples, the nurses explain and normalize the experience. They describe other mothers who struggled with a similar problem and whose babies did well. They reassure the mothers that their child is not being harmed in the process. They inform the mothers that it often takes six weeks for mothers and babies to develop synchrony and ease in the breastfeeding relationship. They normalize that breastfeeding doesn't always just happen and work as soon as the baby is delivered. At the Centre they see that other moms struggle and have difficulties. It frees women to talk about radical change and complexity that has come into their lives with the arrival of their new child. Here is a place where the emotional impact of motherhood can be discussed. At the Breastfeeding Centre there is no need " 'take it like a woman': stoically, singly and silently" (Maushart, 1999, p. 244)

Even to talk to some of the moms there and see that other people are there, trying to get the same help. Or hearing them, 'cause they're sitting beside you, so hearing them say, "He's not latching," or "He's doing this," it's just good information. And it's nice to know you're not the only one going through it, and there is help every Monday, Wednesday, Friday, and right from 9:00 to 12:00.

Talking to, listening and seeing other mothers struggle and seek answers is an acknowledgement of the commonality of motherhood. The mothers see and hear that they are not alone and deficient as they supposed. Instead they see all that they have in

common with other mothers at the Breastfeeding Centre. The word common means to belong equally to two or more (Onions, 1966). Thus the mothers share the difficulties of motherhood. To struggle and question becomes normative. For the mothers to see that the challenges of mother hood are held equally - that all mothers are challenged in some way and at some time, can alleviate self-doubt and guilt. To hold these difficulties in common is a step towards a broader more realistic view of the world and parenting.

The nurses reassure: *It's not just you – you are not the only mother in the world who has trouble with her milk supply. We don't know why you have a low supply, sometimes it just happens. But you've done everything you can to increase your supply. You can't do anything more than you've done.*

The nurses acknowledge both the personal and the particular and the impersonal and the universal. Like Gadow's (1995; 1996; 1999) relational narrative, that incorporates both personal and general narratives of the patient and nurse, so does the hermeneutic space of the Breastfeeding Centre allow both the particularity and commonality of a nurse's and a mother's experience to reside together. The nurses' message to the mothers is that they are both exquisitely unique and exquisitely normal.

The nurses' approach conveys that the mother's present difficulties are never more that she can bear and that mother will receive assistance in bearing this load. She learns she is not isolated in her in difficulties, not alone in her struggles. This learning makes the struggles less difficult and new options appear and arise. Once they realize they are not alone – there is less resistance to what currently is and more attention to what can help this change. Hannah Arendt (1994) has defined understanding as an ongoing activity where we "reconcile ourselves to reality, that is, try to be at home in the world."(p. 308). The process of seeing one's story in the broader context of the world is a first step in this reconciliation process.

Fostering Confidence in their Abilities

The confidence the nurses have in the mothers is illustrative of the deep respect the nurses hold for the mothers. A hermeneutic space is created when the nurses believe that with guidance the mothers will find their own best ways through their difficulties. Nurse

There was a baby who was just going on a really severe nursing strike. Mostly my role was explaining that "This is normal, and don't push the breastfeeding. If you're getting frustrated, pump and give a bottle. It's okay. Just keep on offering the breast, work through it, and you'll work through it." It was over a 2-month period she came in about 3 times, and she sent me a card about a month later. She said, "My daughter and I, we're happily breastfeeding. No more bottles, no more strife. It's so easy now."

In the above situation, the nurse, through identification and delimitation of her role, tacitly acknowledges that the larger and more important role in working through this situation lay with the mother. It was the mother who patiently persisted for two months and kept the breastfeeding relationship going and got it back on track. It was the mother who sought help. The nurse provided a larger vision and offered hope that the nursing strike would be resolved. The nurse's words and reassurance helped the mother keep hope alive. The nurse offered the hope that things would improve, and that they would be different than they currently were. The offering of hope is the offering of possibility and of generativity.

Confidence is engendered by the nurses' knowledge, expertise and desire to instill hope. A nurse reflects on how she attempts to increase the mother's confidence:

I think having credentials and a sense of knowledge. I mean, they're coming to us; we are experts, some of us more so than others ... But I think just giving the moms a sense of confidence, and "We are going to be able to help you." That kind of comes through, the hope and the sort of positiveness. I think the room reeks of positivity; that's what I'd like to think is there.

The positive orientation of the nurses moves away from labeling the women's experience as a problem. Rather things are just what they are – currently you have sore nipples, what can be done to help? The nurses' acceptance of what is happening to the mothers and babies as simply the current situation makes space for the mother to accept the situation. It is neither good nor bad, never any one's fault but rather it is accepted as just what is.

The nurses further acknowledge that this situation happens to other women. The opportunity for the mothers to tell their story and describe their situation validates their experience. Further the nurses' orientation is always towards how can the situation be improved. Joanne Macy speaking about faith, a correlate of confidence said "When we simply attend to what we see, feel and know is happening to our world, we find authenticity"(Macy, 1991, p. 30). Authenticity requires that we not distance ourselves from the world and that we are willing to become personally involved (Nelson, 1982). Nelson outlines both individuality and intersubjectivity required of nurses to respond authentically to patients and have them respond in kind. It is the willingness of the nurses to bring their individual self forward and their willingness to recognize the mothers as beings who struggle, love and suffer that fosters authentic sharing.

When the authentic situation of the mothers is addressed and the false ideals of motherhood are challenged, a breastfeeding mother can begin to dwell more peacefully with what currently is happening and see hope in the future. Hope builds confidence that the future can be different than the present and that change is possible.

A hermeneutic space is one where the mother's capabilities are celebrated and commended. Confidence derives from the word confide – to put faith in. Commendations for effort and celebrations of progress demonstrate the nurses' faith in the mothers. The commendations and celebrations support the mother in taking pride in each small improvement – whether the improvement is a better latch, a more awake baby or an increased milk supply. In turn the mother's increasingly positive breastfeeding experiences with her child supports her growing faith in herself and her abilities.

Nurse Gwen

> *You see these babies growing and these moms becoming more confident and brighter every time you see them and it's that "I grew him or her" "I did that" "Inside and outside my body, I grew this baby" and I think it so rewarding and it's natural and I think that's important.*

Nurse Betty

> *Those women who do have a lot of milk or who can build up a supply from not having had enough, they have, I definitely sense, a real "being proud" of their body or their breasts or their body image or their capabilities. So*

that idea of [pause] it's just nice to see that empowerment that you can see evolving in a woman as she realizes the power she has over the ability to feed a baby. And having more than the baby needs; like, that's the ultimate. Having a big, fat, roly-poly baby, all because of her, you know. So you definitely see a woman having — developing a greater respect for her own abilities.

Mother's perspective reflecting on what allowed her to become more comfortable in her mothering role.

You get confidence when things work, right? Time has a lot to do with it; time, being confident, being comfortable, having someone there to support you that's professional and that's educated and not judgmental. (laughs) And just, I don't know; it was really the whole process of being able to go back and follow up when I needed to. And you're confident 'cause you know whatever issue's going to come up next week, you can resolve and just relax about it.

The above mother trusts that together with the nurses any breastfeeding or parenting difficulty can be dealt with. This trust builds her confidence in herself and the process of breastfeeding. This trust and confidence in herself and the process allowed her to relax into what currently is and not project doubt and worry into the future.

It is interesting that the nurses identified confidence arising from the mother's capabilities. The mothers did acknowledge this aspect as well but also noted they were confident because of the nurses' capabilities to assist them.

Confidence is also fostered when the hard work of the mothers is acknowledged. Two of the mothers who participated in the study were ultimately unable to develop a sufficient milk supply to exclusively breastfeed their babies. This is an uncommon experience and everything was tried to increase their milk supplies. The mothers initially tried using a breast pump as well having their baby nurse. So in addition to feeding every two to three hours they would also use an electronic breast pump to stimulate an increased supply. They took domeperidone, a galactogogue, and fenugreek, an herbal supplement. Both can work for some mothers to stimulate and increase milk supply.

The mothers would switch nurse – alternating which breast their baby was nursing on throughout a feed. They would do breast compressions as their baby nursed to increase the speed of their milk flow and keep their baby actively nursing. In an attempt to increase their milk supply, they would organize their lives so that for twenty four to forty eight hours at they would do nothing but rest and breastfeed their new baby. Each of them tried a supplemental nursing system (SNS). A SNS holds formula in a container that hangs between the mother's breasts and delivers supplemental formula through a feeding tube taped to the mother's breast. The SNS allows the baby to get the extra nourishment it needs at the mothers breast, reduces the possibility of nipple confusion because the baby is not being bottle fed and increases the amount of sucking the infant does at the breast which should stimulate increased milk production. Both the pump and the SNS need to be carefully cleaned after each use and the milk has to be safely stored. As a result of the above activities these mothers took on the double workload of breastfeeding and a workload of greater than that of bottle-feeding. Despite all these efforts, their breastmilk supply required supplementation to adequately feed their infants. Tina describes her experience:

> *I'd see the other moms there having no problem whatsoever. It's hard 'cause it feels like you're not being — you're not giving your child everything, and I'm kind of ripping her off, not being a good mom, "What's wrong with me? Why am I not producing?" You know, all those things go through your head, so that was a bit tough. But they reassured me that there's lots of different avenues. They still weren't pushy, they weren't — even when I wasn't producing, it's not, like I felt guilty, they reassured me that this happens, and all you can do is try, and if you've exhausted all your options, you've given it A for effort. So it was kind of, like, "Oh, okay, alright." 'Cause you kind of think, "They're so pro, they're going to think that my child's not going to get the best she can," and that kind of thing. But I never felt that way, at all, so it was supportive. They're very caring. They have your best interest at heart, is the big thing — yours and baby's best interests at heart. You feel very comfortable with them handling your baby, that kind of thing. Even today,*

I can't imagine leaving Lisa with anybody but Grandma. So to feel comfortable to hand your baby over to somebody is something. They were very helpful.

Another said:

Realistically, I have now learned that you can only do what you can do. You need to exhaust all your options, and you're not a bad mom as long as you've given it your all and you do the best to make your baby healthy. And he's a very healthy baby, so that's all I can ask for and that's all I can do. Your body does things for a reason. And it kind of took the pressure off.

These mothers' breastfeeding experiences were bittersweet. They would have liked to have exclusively breastfed their babies but they were thankful that they had the opportunity and support to breastfeed much as they did. They also knew that they had done everything possible to feed the child and had no guilt about their situation. They were confident that they had done the best they could possibly do for their child. To not succeed at something they had planned for all throughout their pregnancy and to still believe themselves successful mothers, speaks to the confidence these mothers were able to develop in themselves as parents.

In the situation described above the primacy of the mother-child interaction is evident. This is unlike Ezzo's method where the goal of the scheduled and obedient child is more valued any unscripted parent-child interaction. These situations are clearly not cases where "the goal, then, appears as more real and more valuable than the activities it engenders; and acts themselves are merely instrumental to an end whose nature is more final and complete" (Macy, 1991, p. 104). In the situations above the goal of exclusive breastfeeding became subservient to the realities of the mothers' ability to feed and to the process of breastfeeding for each of the mother-baby dyads. The nurses assisted the mothers to move beyond ideals of exclusive breastfeeding and focus on the activities they were doing, deemphasize what they were not doing, and to find success in what they did. For the nurses and these mothers "means are not subordinate to ends so much as creative of them – they are ends-in-the-making" (Macy, 1991, p. 105).

Understanding as a process

Mother's perspective

It's a process, yes. You're over there for an hour, hour and a half while your baby feeds, so you learn more each time you go.

Mother's perspective

Breastfeeding it is a very ongoing thing, and it's the ongoing support that's important because even when you think you've got it, your baby changes all the time, your baby is different, then finding what you did before isn't working, and your routine goes out the window and your baby's fussy and you don't know why, and you almost need to step back and start again. It so important to have someone to turn to.

The above comments from mothers indicate that breastfeeding and understanding are processes. There is never an endpoint in either breastfeeding or understanding. The mothers' description of the process of understanding points to the temporality of understanding. That is, what we understand is a function of time. One never understands something forever and for all time. There is not a finite endpoint in this type of understanding – one can always understand differently, more fully or more deeply. Understanding is never a place where you fully arrive – there is always the potential of movement to a new understanding. There is also an unpredictability of understanding. Gadamer (1998) acknowledged this uncertain outcome: "For an understanding of this kind never ends by arriving at a predetermined destination" (p. 10).

For Gadamer (1999) understanding takes place in all aspects of human experiencing. He views understanding as primarily an iterative act where interpretations, which are a limited form of understanding, are continually placed back into the process of understanding. Further, understanding is an open historical process in which the interpreter stands in an already constituted interpretation. The mothers' experience represented by their house and home is an example of an already constituted interpretation.

The process of understanding for Gadamer (1999) is always linguistic. "That which can be understood is language" (p. 475). Language is not just the language of a one-way message delivery system. It is always the language of conversation in which the other encounters the interpreter in dialogue. Understanding has the character of a process

that one participates in rather than something constructed by a subject (Risser, 1997, p. 7). Taylor (1991a) said "dialogue is at the very Centre of our understanding of human life " (p. 313). Taylor describes the dialogical self as the precursor to meaningful human action. This action occurs when in the rhythm and flow of dialogue by agents who understand or constitute themselves "intergrally part of a 'we'" (p. 311.)

Thus process of understanding is fundamentally dialogical – that is it takes place in conversation where another is encountered in dialogue (Gadamer, 1999). What is other to the interpreter draws them into an exchange in which a new understanding occurs (Risser, 1997). Gadamer also said that our words in conversation "are supposed to make the other think…The discursivity of thinking and the ideal infinity of every conversation means that thinking is without limit"(Gadamer, 1997, p. 387). Conversation opens up to possibility and generativity.

The nurses begin building their relationship and "thinking" with the mother by exploring the mother's already constituted interpretations. The nurses' intent is to start with mothers' interpretation of the situation and move forward towards new understandings for both. The nurses commitment to this starting place acknowledges that understanding involves "seeing each other" (Bergum, 1999, p. 177) and "requires dialogue" (Bergum & Dossetor, 2005, p. 11). Both actions initiate the creation of a relational space.

The following excerpt demonstrates how the nurses begin the dialogue oriented towards "seeing "the mother:

> *Because to me, why they think they came in is what the important issue is. I don't care what I think was the reason they came; that's not where we're at. It's why they're there. So I pull that out. I can't operate — I can't even start to work with them until I know why they came through the door. And what other things they're concerned about. And what other influences. Like, it might be they don't want to be there, but their doctor says they had to come. Okay, so we need to then explore why don't they want to be there; that's the important thing. I guess the other thing that is important is looking at what else is going on with the lady like postpartum depression or a chronic illness. We need to know about them.*

The desire of the nurses to see and know the mother is the starting point for the continual evolution of understanding. The nurses' questions reach back to understand the grounding and point of view that brought the mothers to the Breastfeeding Centre and to begin the process of placing current interpretations into dialogue to come to a new understanding.

Current interpretations are always historically grounded and play forward from what Taylor (1991a) has called the "inescapable role" (p. 309) of the background.

> every interpretation is grounded in something we *have* in advance in the sense that the interpretation has already a totality of involvements which is already understood. Furthermore, every interpretation is grounded in something we *see* in advance in the sense that there is a point of view with respect to what is understood. And finally, every interpretation is grounded in something we *grasp* in advance, in the sense there is a conceptual scheme that guides the interaction (Risser, 1997, p. 48).

In the above quotation Risser (1997) lays out Heidegger's forestructure (*Vorstruktur*) of understanding. Human involvements are inherent in every interpretation. The earliest literal and figurative meaning of involve was to wrap around (Onions, 1966). Thus we can think of involvements as our experiences, beliefs, culture, relationships that have enveloped and are enveloping our lives. These involvements become integral to our understandings and are a precursor to our interpretations. We also see from a particular horizon and use particular conceptual schemes to frame our previous experience and understanding. Thus the process of understanding never evolves from a blank state or a void.

Nurse perspective

> *Sometimes it's challenging to know where to start when they have too many misconceptions and so much wrong information. I try to tackle what I think will be least threatening to the woman's' belief system. I try to ascertain where they got the information "what have you been told and by whom?" Try to honor what they've been told and help them understand how whoever told them might come to think like that and at the*

same time try to show them what we know currently that might cause us to think differently about that.

The nurses are very aware of the power of conflicting information to confuse and frustrate the mothers. They work to be consistent in their approach and recommendations. They acknowledge conflicting information saying *"There is still debate" 'Some people think" "As best we know now" "I know you might be told".*

The proceeding statements let the mothers know that breastfeeding knowledge is not complete and final. That there are different opinions and recommendations but the nurses will assist parents to understand the perspectives and find an understanding that will work for them and their family. The mothers and nurses together engage with each other in conversation. The multiple meanings and understandings of a situation are acknowledged and through conversation and dialogue new meanings and understanding evolve.

There was true flexibility in the process – changes occurred as the understandings of the partners in the relationship changed. Unlike Ezzo who "allowed" flexibility (deviation from the schedule) when outside forces (public opinion) were in play, the nurses' approach to breastfeeding was that things can and will change and the commitment of the nurses was to change strategies and approaches as needed.

Mothers' perspective

Once when my baby wasn't latching properly I don't remember exactly what she said to me, but I just felt "Oh, she really understood me, what I meant." She said something about "You know, when they get something from your breast, it's the reward." That's what she said to me. I couldn't remember what I asked or what I said, but that was her answer. And I was thinking " Oh my goodness, she really understood."

In the above quotation the mother captures the richness and importance of understanding. Those who would cut short the process of understanding and proclaim that this is how this event or phenomenon is to be understood are guilty of indoctrination. Indoctrination is:

> …a short-cut in the transcending process itself, which it arbitrarily interrupts by pronouncing apodictic statements as though they had the reliability of facts and

> figures, it destroys the activity of understanding altogether. Indoctrination is dangerous because is springs primarily from a perversion, not of knowledge, but of understanding. The result of understanding is meaning, which we originate in the very process of living insofar as we try to reconcile ourselves to what we do and what we suffer. (Arendt, 1994, pp. 308-309).

Indoctrination introduces violence into the situation by a premature closure of understanding. At the Breastfeeding Centre the nurses' focus on questioning, their striving for connection, their acknowledgement of heterogeneity and difference keeps open the possibility of understanding and avoids the violence of indoctrination. The nurses' actions supported the mothers in the process of reconciliation of their life experiences and allowed maternal meaning to develop.

Although the nurses used scientific discourses to support their reasoning, these discourses were not used to trump the mother's experience, or short cut the process of understanding. For instance when talking about why a schedule might not be the best for a young infant – the nurses would speak of the immaturity of the infant nervous system, the size of their stomach and the need for frequent feeding. Yet the power of the scientific discourse was moderated by the acceptance that the mothers would chose their own course and act on the information given in their own way. The concept of compliance in this setting was a non-issue. The paternalistic and coercive assumptions underlying compliance (Hess, 1996) are the antithesis of care at the Breastfeeding Centre. As a result the nurses' practice was oriented away from all encompassing prescriptions, right and wrong answers and allowed the nurses together with the mothers come to a sense of truth.

Challenging the Discourses

All discourses can serve to overpower and threaten, or more in a milder for to raise question and doubt (Foucault, 1980). As humans we are all susceptible the seductiveness of a discourse's message. Often these discourses are difficult to challenge on our own. – that is to say what is concealed in the discourses remains concealed. An important component of the nurse's work is their constant challenging of the discourses. These challenges may be as simple a nurse's statement "*well that's math* (referring to the average times a baby should feed) *but this life* (what the nurse and mother were observing

about the baby) *and life is more important*". Alternatively it might involve, the woman's whole family in bringing about change.

As noted in Chapter Three breastfeeding is an ideologically laden endeavour. Mothers and nurses are challenged to navigate their way through the deeply polarized views on breastfeeding and motherhood. Some motherhood and breastfeeding discourses can distract the mothers from an authentic involvement with their babies and themselves. "Instead of the projective work of authentic understanding which recovers the primordial meaning, *Dasein* is lured into complacency with the prevailing public interpretation of things" (Caputo, 1987, p. 62). Krell (1993a) similarly describes the challenges of humans searching for truth in his preface to Heidegger's "On the essence of truth":

> Dasein discovers beings, but also covers them over: aware of its possibilities, Dasein is nevertheless "thrown" into the world and "ensnared" by it. Hence Dasein is "equally in truth and untruth". Open to beings and to its own being possible, Dasein nevertheless relinquishes this openness in exchange for the security of whatever "they" say is true. It lets truth slip in the same oblivion as Being and finds its "truths" as many scintillating beings there before it, polished yet manipulable. (p. 113).

Caputo and Krell above both speak of the challenges humans face in coming to understand. Dasein is always pressing towards an authentic future – at the same time this movement forward is also a movement of retrieval. Caputo (1997) describes the ontological loop that links Dasien's forward and backward movement, that is "its futural projection and its already having been" (p. 60). Dasein is projected ahead towards the future "always to possibilities into which it has been all along inserted" (p. 60).

It is easy for humans to be caught up in common interpretations of ideas and experiences and accept them without thought or question. For Heidegger, truth was not about correspondence between knowledge and some object. Truth was about uncovering the presuppositions that exist in such statements. Truth then becomes concerned with unnconcealment or disclosedness.

Falling into the security of what "they", the discourses, say is true is a common human experience. It is much more difficult to more beyond these polished messages to reveal or " to unconceal" truths. The spaces created at the breastfeeding centre support

the mothers in the process of making their way past the challenges of complacency and towards authentic understanding. Challenging the prevailing discourses was an important component of a creation of a hermeneutic space at the Breastfeeding Centre.

Weaning Discourse

Below is a nurse's description of one mother's struggle to move beyond prevailing public interpretation offered by societal discourses about weaning.

> *One day this teen mom came in — or she was probably in her early — no, she was probably still a teen. She came in with her 3 1/2-year-old who's still breastfeeding, and was trying to wean. She came in with a friend who had a young baby, who I thought was the client, and so I'm talking to this woman and. she goes, "No, no, I brought my friend here who has this 3 1/2-year-old." I go, "Oh." It was almost like — she had her head down low — embarrassed. By the end of it, she was just walking out so proud, 'cause it was just, "Oh, my goodness. Congratulations!" Because everybody had been cutting her down for breastfeeding this long. And granted, she was working on trying to wean this baby, but at the same time, she had a great relationship with her child, who developmentally was all there, never been sick. So just sitting down with her,— she was all ready for weaning and getting information on weaning, but she was embarrassed! It was just nice to see that sort of instant transition of just her feeling proud rather than embarrassed.*
>
> *I think with regards to her, she was having a very hard time emotionally. When you consider what this poor girl had gone through, I think the breastfeeding was a huge emotional component for her and to what she needed, as well as what this baby needed. So just really approaching it as in it needs to work for her and her baby, and that you don't have to quit cold turkey, and it's going to be hard on you as well as the child, so really focusing on her and what it's doing for her. So we just sort of talked about how to start with eliminating just the day feeds and hold onto those night feeds if you want, or just sort of different approaches of never refusing, but saying, "Later," or distraction; just sort of going through and really*

focusing far more on the emotional, 'cause that's obviously the point — and she knew this, too — this kid can get everything it needs from a cup and a plate and that it was just this real emotional bonding. So it was just more clarifying where she's coming from and the emotional needs of her 3 1/2-year-old, and just meeting them where they're at, instead of coming up with this concrete "This is how you wean, and you must do it" kind of thing.

Unlike the breastfeeding and mothering discourses discussed in Chapter Three, discourses that state when and how mothers should wean and what is proper parenting, the nurse offered the young mother another way of reacting to her current situation. The nurse applauded the mother for her success in breastfeeding for three and a half years and commended her on the health and well-being of the child. These nursing actions had the effect of challenging the discourses about a "proper time to wean" and the "acceptability" of the mother's actions.

"The work of recovery cannot proceed except by clearing away the superficial and commonplace understanding of things which systematically obscures our view and subverts the understanding" (Caputo, 1987, p. 64). The nurse used questioning, dialogue and acknowledging the experience of the mother and child to begin the work of recovery. In the process the mother was shown that both the emotional and physical dimensions of her relationship with her child could be respected. Further the nurse demonstrated trust and confidence in this mother's ability to honor both these dimensions of the relationship. The nurse was in effect showing the mother how to continue to be relational with her child – when societal discourses where encouraging the mother to radically alter her relationship.

The nurse's suggestions implied that the mother's attunement to her child would lead her on the path to weaning and that the ongoing dialogue she was engaging in with her child could guide her on the path. Imbedded in the nurse's actions was the message that although the discourses may raise doubts and uncertainty for the mother, the maintenance of the ongoing relational dialogue and attunement to her child would help her find her way. The mother's knowledge of and confidence in her self and her child,

allowed her choices "that open broader vistas to perceive and know, wider opportunities to love and act" (Macy, 1991, p. 94).

Breastfeeding Nazi Discourse

Mother's view

But they kind of made it seem like it's okay. I was expecting the militia of breastfeeding, and them to say, "You have to nurse, no matter what." The baby's dying, and you still have to nurse. But it's just about really feeding the baby and bonding, and at that time, I just thought, "If I don't nurse, then I'm a bad parent. I'm starting off already bad, so you've got to get this." [both laugh]

Even the lactation consultants going, "If you have to supplement, it's okay." Just feed your baby however you need to You know? And it was weird to hear that coming from the experts, but it was good to hear it. It took the pressure off. I guess that the biggest thing is, in all of this, it's taken the pressure off. Just feed the baby and do your best, and love her. I've seen people breaking into tears that just couldn't nurse, and it's terrible! And I never felt like that.

In the discourse section of the paper the term Breastfeeding Nazis was raised and this mother mentions the "breastfeeding militia". These terms are often given, sometimes undeservedly, to pro breastfeeding women and health care professionals. The terms create a vision of a powerful force riding roughshod over a mother coercing her to breastfeed against her will. The terms resonate with the intense, palpable emotion and vulnerability associated with women's experience with breastfeeding. The terms also speak to a denial of the particular and the individual and the indoctrination and collateral violence experienced by those on the receiving end of a particular form of breastfeeding promotion.

Hausman (2003) talks of the challenges of being both pro breastfeeding and pro woman. She acknowledges that at times breastfeeding advocacy colludes with

traditional scientific misogyny. Yet science is both discourse and information – so how do we value and use the information and not become mired in other representations and assertions that are present in scientific discourses? Further, infant feeding is a social practice that exemplifies how people interpret scientific claims about health. In the above mother's reflection she seemed to equate the' breast is best' slogan with breast is mandatory, or else. This evidence of the multiple discoursive elements present in any discourse about breastfeeding.

Hausman describes her challenges in writing about breastfeeding "The trick is to balance the analysis: to note where arguments rooted in biomedical evidence ignore political realities, and then to suggest when interpretations of socio-cultural conditions should pay attention to biomedical claims about health" (p. 15).

The nurses face a similar challenge. Although the discourses as a rule remain unnamed and unrecognized background in the nurses' work (Babywise is an exception to this rule), the nurses work through in partnership with the mothers the multiple tensions the discourses present. Discourses are never simply open or closed, good or bad. While some breastfeeding advocates may be portrayed as "breastfeeding or else proponents", this is not an accurate portrayal of the nurses at the Breastfeeding Centre. For these nurses, it is never an either or choice. Rather is it is always a question of balance - how to attend to both their commitment to fostering breastfeeding and responsive parenting and how to attend to individual needs of a woman. It is a position that demands that the nurses be skilled in the technical, the scientific, the relational and the experiential.

The nurse's skillfulness in all of these areas and their ability led to a sense of truth arising at the Breastfeeding Centre for the mothers interviewed. The last component of the hermeneutic space created at the Breastfeeding Centre in this chapter is truth arising in collaboration.

Truth in Collaboration

> *Truth in collaboration comes not from an disembodied knowing, thinking, and doing that reduce self and others to being things (Aoki, 1990, p. 49)*

As noted at the beginning of this chapter, none of the dimensions that make up the milieu of the Centre and encapsulate the interactions of the nurses, mothers and babies exist as distinct entities that can clearly be demarcated from one another or linked in a sequential model. Rather all of the dimensions described depend upon, overlap and inform each other. However, I have placed the 'truth in collaboration' dimension of the hermeneutic space of the Breastfeeding Centre at the end of this discussion because it deals most directly with the research question that enlivened this research study – "How does a sense of truth arise in the nurse-patient relationship?" It is important to note that the previously described dimensions contribute and are vital to full understanding of the truth in collaboration dimension.

André Gide, a French philosopher and winner of the Nobel Prize for literature, said *"Believe those who seek the truth. Doubt those who find it."* (http://www.andregide.org/remembrance/nytgide.html). Both in his personal life and in his essays and novels, Gide was known for his seeking of an authentic life – a life lived with integrity and conviction. He knew that the process of seeking truth was foundational to authenticity. For Gide, those who would proclaim the truth were seen to foreclose the pursuit of authenticity and act as perpetrators of dogma.

Seekers of Truth.

The nurses and mothers at Breastfeeding Centre were also seekers of truth. Together they questioned, listened, told their stories, shared their ideas, laughed, cried, and challenged societal discourses. In the process both mothers and nurses genuinely and generously sought truth in dialogue.

Nurse perspective

> *Truth, to me, with a client, is honesty, of just feeling like you're really both doing your best, letting all the walls down, working towards a common goal. And you can't do that, really, unless both people are totally honest, whether it be honesty on my part as in, "You know what? What I said earlier isn't working. We've got to try something else"; being honest that this is trial and error. And for a parent, it's being honest about what's truly happening and what her wants or her needs are. Some parents can't be truthful with themselves, let alone a nurse. So it's*

helping the parent become truthful with themselves and hence, you with them also in the process.

The nurse recognizes that debilitating traditional motherhood mythologies and the new equally unworkable "having it all" mythology of motherhood often results in such maternal confusion that it is difficult for women to identify what they as individuals want or need. Thus part of truth in collaboration involves the nurses helping the mothers gain clarity for themselves about their desires and needs. The nurses show the mothers that "As an interpreted world, it can be interpreted differently" (Smith, 1999d, p. 117). The nurses accept that the search for clarity is part of the process of understanding and it is not viewed as an attempt by the mothers to mislead or be untruthful.

Mother's perspective

If you're talking about truth and honesty, you discover very quickly who you can be yourself with and who you can't. But you know when I was there – I could just be me and it was good to get some back and not be thinking I had to be careful of what I could say.

Both the mother and nurse identify that it takes two people speaking openly and genuinely to seek and to find truth. Here truth does not reside in empirical facts that one imparted to the other. Truth arose and evolved because of their mutual seeking.

This mother experienced the Breastfeeding Centre as a place of safety. The Centre was a place where she did not have to be guarded and vigilant – a place where she could put her authentic self forward. There was reciprocity that occurred when she shared – it was a place where she got "some" back. Although she did not specify what she received in return – it clear that while she gave of her self, that is when she was "just me", she also received in kind from being at the Centre. Reciprocity was inherent in her interactions and truth in collaboration was dependent on this reciprocity.

There was reciprocity in their sharing of experiences and ideas. Together the nurses and mothers sought out "truths" that would work for them at this moment and place. They knew that these truths would change as the mothers, babies and nurses changed. As discussed in the section understanding as a process, truth in collaboration, is an infinitely iterative process. That is just when we think that have the truth, it shapeshifts and perhaps disappears, and the truth seeking begins again. At the

Breastfeeding Centre truth is never a fixed entity or end. There is a realization that truth in collaboration needs to worked out in the context of the Now.

Nature of Relationship

Truth in collaboration is dependent on the nature of the relationships occurring which in turn is dependent on the quality of the conversations taking between the participants. Quality relationships and conversations are grounded in awareness of our interdependence, in relational respect (respect for self and respect for others) and mutual power (Bergum & Dossetor, 2005).

Truth in collaboration is truth sought in and through relationship. These truths exist in an social context and thus the seeking of truth and knowledge are always contextualized (Purkis & Bjornsdottir, 2006). Nurses and mothers can be described as " 'being(s)-in-relation,' concerning the individual as well as the social group." (Irigaray, 2002, p. 104). This concern for both the individual and the group is an acknowledgement of the intrinsic interdependence of all beings and all relationships. Irigaray (2002) goes on to describe these relations as uniting "the necessities of the moment and those of eternity, without sacrificing any singularity, and while respecting the exigencies of a temporal constitution." (p. 104).

"Being-in-relation" requires attention as well as concern. Bergum & Dosscetor, (2005) have termed paying attention to questions such as "*Who am I? Who are you" and What is our connection*?"(p. 81) as the foundation of relational respect. Relational respect encompasses respect for self and respect for others (Bergum & Dossetor, 2005). The nurses respect and value their own expertise and judgment. In turn the mothers value and respect the nurses' expertise.

Nurse reflection

> *they do come to that door expecting a level of expertise, and it can't just be the airy-fairy little support piece. You know? "Oh, you're bringing D! Do you want to have a cup of tea?" No. If they wanted that, they would search out something else.*

Mother Reflection

they were all so good. It wasn't just breastfeeding, you could ask them about anything, car seats, diaper rashes, what kind of toys – you name it they could help you.

The nurses also valued the mothers' knowledge of their baby and of themselves. They made a place for the mothers to respect themselves and what they knew and wanted.

Nurse reflection

You know most of them are now in an environment that they aren't familiar with. They have a whole group of new acquaintances that are telling them things, and the people closest to them are telling them things. I guess I see our role as supporting them in their values and their values for what they want for their new baby. What do they really value? You know that is evolving for them from day one and it's so important to how they parent.

Respect for self and for their personal expertise is only one necessary component for truth seeking. Self-respect must occur simultaneously with respect of others and for persons. Nurses and mothers each brought different experiences, knowledge and understandings to the relationships at the Breastfeeding Centre. One partner came seeking knowledge and guidance, and the other partner in this dialogue sought to assist and teach. However these differences in intention and position did not result in a relationship "founded on a hierarchy" (Irigaray, 2002, p. 104). These were not relationships of power-over but rather were relationships of power-with (Bergum, 2007; Chinn, 1995). Truth in collaboration can be thought of as creating a single moral narrative from the multiple narratives that make up the nurses and mothers lives. In the co- creation of a single moral narrative, "no one voice dominates" (Hess, 2001, p. 142). The nurses, as professionals acting in their professional setting, were aware of the institutional power bestowed by their positions. However the nurses' stance of "Whatever works in your house", by returning choice to the mothers, acted to ameliorate positional power imbalances.

Philosophical Views on Truth in Collaboration

Gadow (1984, 1995, 1996) was one of the first nursing philosophers to speak of truth in collaboration. Her ethical framework encapsulates the temporal, the eternal and the singular that Irirgary (2002) describes above. Through her framework of general, personal and relational narratives, she addresses the particularity of the individual and the multiplicity of our social, cultural, gendered, historical and political world. In her model, as nurse and patient weave their way through this maze of individuality and universality, they can come to a relational narrative - a truth that is co-created. Relational narratives reflect intersubjectivity and mutuality between both partners co-creating the story (Gadow, 1984). Nurses and patients are inherently reliant on one another and the truth that they create together sustains both.

Similarly Smith (2002) describes the necessity of a shared truth. " In actuality, Self implies Other. If there is to be truth in the world, it will be only truth as shared, something between us. Such is the foundation for truth in the age of ethics" (p. 23). In Gadow's words there cannot be a truth that is more important than the relationship and the truth is always contexutalized. A shared truth is temporal and cannot go beyond the confines of the relationship.

Gadow (1995a), using a metaphor of exploration, goes on to say "The truth reveals itself most fully in the paradox, irony and contradictions that distinguish compelling narratives" (p. 213). Within this irony and paradox lays a richness of meaning that cannot exist for a dualist mind or a mind requiring certainty. From Gadow's perspective there is no need to quash or manipulate an individual's story so it fit's a preordained agenda. Mothers are allowed and supported to be all that they are and the nurses accept these different stories and add their own knowledge and narratives.

A shared truth implies an openness and willingness to listen, a receptivity, to that which is not known, to that which is foreign. The process of becoming aware of and open to that which is Other, brokers no stereotypes, no over used societal discourses and no complacent responses. This process challenges to honour both our distinctiveness and our sameness. This openness demands authenticity of the participants and in turn the authentic response connects to others in a dynamic fluid interchange and forms the basis of our ethical core." *"an authentic person is no mere individual, an island unto oneself,*

but is a being-in-relation-with-others, and hence is, at core, an ethical being." (Aoki, 1990, p. 21)

Many authors have spoken of the between space of relationship. Buber saw wisdom arising from the "in-between" of human interactions (Freidman as cited in Montgomery, 1993, p. 22).

The Gathering of Truth

Steven David Ross (1997), in his wide ranging reflections on truth, speaks of the "gathering of the truth". His description implies that truth is not facts, or correspondence or coherence with some concrete entity:

> At the heart of truth lies a wonder, a sacred mystery, which Heidegger asks us to encounter again, repeatedly, the uncovering of things in their hiddenness, all gathered into language, as truth. The truth that can emerge only as untruth remains in this gathering, offers itself in wonder. This wonder, given as a gift, comes from the good, responds to the good. For it demands, and calls and touches us with awe. And it is given as a gift, not demanded or possessed. We find ourselves in wonder at the goodness of the earth to which we respond in truth. This goodness is not compared with badness or evil, not a good gathered in opposition with the bad, but a good that calls and beckons and entreats, asks us to respond. The wonder is a beauty that calls for endless response (Ross, 1997, p. 3).

The following quotes from a mother and nurse demonstrate the gift of truth that was given to each through their relationship with the other.

Nurse experience

> *Then she said at the end, "I couldn't have done it without you." That was just so — just like [sighs]. And you don't realize the impact, 'cause so often, once the problems are fixed, you don't hear from them again. So it just made me realize why I love what I do, when that's the effect you can have on people's lives.*

The difficulty the nurse had articulating the ineffable feeling arising from the gift of gratitude and truth speaking that she received from this mother. The

truth of this mother's statement and the mother's authentic gratitude called and touched the nurse with awe about the goodness of the earth.

Mother's perspective when asked if she experienced a sense of truth at the Breastfeeding Centre.

> *That's a very emotional topic for me. Those people have to be very genuine, I think. I'm sure all nurses aren't non- judgmental but when I was there it was just total acceptance. It can sound kind of flaky, but it was such an emotional time and they were <u>really</u> [pause] really accepting of whatever I said. They really, I didn't feel, judge me. I never felt they walked away saying " What an emotional idiot." That's a big one for me, because I judge people all the time.*
>
> *I think " sense of truth" is a good way to put it. I almost wish that I could have more relationships with a lot of those nurses because you don't often meet people that are that real or non-judging of you. People aren't like that. So when people are really not doing it to me, it's such a nice feeling. So it was a deep kind of [pause] approval – it's hard to find the right word. But I feel really grateful to all those women, because they made such a really <u>big</u> time in my life so special and so happy.*

This mother, although struggling at times to express her experience, shows the depth of feeling that being heard and accepted engenders. The safe milieu of the Breastfeeding Centre and the nature of the nurse patient interaction resulted in a sense of truth arising. Truth in collaboration allowed her to be genuine and to have someone responding in kind. The mother also knew that the "sense of truth" she experience arose as a result of the relationship she had with the nurses and that this type of relationship was something to be cherished and be thankful for. The gift of truth also made an important time in her life happy and special. This mother also experienced the gathering of truth as described by Ross.

Truth is a response to the wonder and the mystery and the good of life in all its wholeness. Truth is not something one can have or possess. Rather, the seeking and gathering of the truth that Ross describes is a great act of generativity. Unlike many conceptions of truth, including Ezzo's, the truth Ross describes does not attempt to make

static, what is relational. We are called to look for and bring forth possibilities of new understandings and new ways of being. The gathering of this truth asks us to look repeatedly together for what is shown and known but also what is hidden and unknown. Truth asks us to bring forth what is presently understood and not yet understood in our interactions with others but also in our interactions with the Earth, our home.

The idea of the good is interpreted by Ross, as nature's abundance that gives both truth and beauty as gifts. Thus the gathering of this truth requires responsiveness not only to the human condition but also to the wholeness of our earth. It requires us to be profoundly aware of and concerned with the Other and our world. It asks us to use our collective intelligence to respond to the needs of children, of adults, of nature and the planet.

Myrhold (2003) makes an argument that nurses have an ethical obligation not only with those we are close to (the experienced Other) but all also to the un-experienced Other. She argues there are always issue of justice, fairness and social responsibility to be addressed that extends beyond established relationships.

Jardine (2000) makes a similar call that we attend to the well being of the planet in his ecopedagogical essays. Both authors are proposing that our consideration for the individual has ramifications for the general and the totality of the world we live in. Acceptance of the gift of truth does not occur without the compassionate and thoughtful inclusion of the other and of the needs of the planet and all its species and diveristy.

In contrast, Ezzo's world can be conceptualized as control run amouk. Control and competitiveness in our world has paralyzed and stopped us from uniting to gather the goodness that is there. Control does not call or touch us with awe. Instead control can diminish, stagnate and destroy. Control implies struggle and resistance. Yet Ross's gathering of the good calls for a simple and never ending response to what is before us. In this responding there is no need to struggle or resist. The responsiveness that Ross describes does not involve dualities or polarities to rail against.

The truth that Ross describes, like Gadow's relational narrative truth (1995, 1996, 1999), is encompassing of seemingly paradoxical events. For example, there were two mothers in the study who believed they had successfully breastfed and were content with their breastfeeding accomplishment, when they had only been able to produce a fraction

of the nourishment that their babies needed in a day. These mothers had tried everything they could to increase their milk supply, and had to supplement – yet still established a "successful" breastfeeding relationship with their children. In an arbitrary empirical world true breastfeed feeding success is might be interpreted as breastfeeding without supplementation for six months postpartum and the experience of these mothers as triumphant and something to be viewed with pride would have been diminished.

The truth Ross describes require an entering in and being in tune with. The gift of truth from goodness honors these mothers' efforts as much as it honors the product of their efforts (the production of milk). It acknowledges there are multiple products of effort – in this case a close responsive bond with their child, a receptivity to what life has to offer and does not fix their experience into the either or box of successful or not successful.

Truth as an Outgrowth of the Gathering of the Good

Truth in collaboration results in a "sense of deep human resonance" (Smith p. 139), for the partners co-creating the truth. For when truth is co-created there is not a superficial acquiescence of one's will to the will of another. Truth in collaboration and more broadly the entire nursing stance of Whatever Works in Your House, are vivid examples of power sharing and egalitarian processes. Truth in collaboration involves a generosity of spirit and genuineness to be vulnerable and authentic with one another. Truth in collaboration provides a glimpse into the meaning of deep connection and understanding. Authenticity, connection and understanding are reflect the gathering of the truth.

Eastern Perspective

The yogic tradition uses the Sanskrit word *satya* for truthfulness. Truthfulness is one of the five yamas, or restraints which make up five of the ten ethical guidelines of classical Yoga as set down by Patanjali. Judith Lasater, (Lasater, 1999) a yoga scholar and teacher describes the outcome of hearing and speaking truths:

> *Hearing words that express truth helps us to experience a deep recognition that unconsciously we already know the truth. Upon hearing such words, we feel that some deep, essential part of us has been seen, hear, and understood. When we sense such profound acknowledgment and*

understanding, our soul receives an almost primordial comfort. We feel at home from the inside out, and we are inspired to act from that place of virtue within ourselves. Thus, beginning to practice satya by bringing more awareness to our words not only aids us in our lives and relationships but also contributes to the well-being of the whole world. Why? Because to speak from satya is to bring out the very best in others. When we do this, we are creating at this very moment the world we want to live in, a world based in clarity and connection. (p. 80).

Interlude, Reflection and Segue.

This study is concerned with how a sense of truth arises, rather than what truth is or what is true. The words Whatever Works in Your House and the concept of an hermeneutic space was used to capture and symbolize, the conditions under which truth can be discovered and evolve. These conditions cannot be separated from truth itself. These conditions can be considered a gathering of the truth, a responding to satya and a bringing out the very best in others.

The world that Lasater describes parallels Ross's description of the good. The mothers' and nurses' descriptions of their experiences at the breastfeeding centre are reflective of a place where the mothers and nurses together recognize what they already know. That is a knowledge that is rooted in relationship and is beyond the discourse. A knowledge that frees and can transcend oppressive societal troupes. The following chapter will describe the results of this shared truth and freeing knowledge.

CHAPTER SEVEN
TO SETTLE: THE OUTGROWTH OF SEEKING TRUTH

A mother returns to the clinic about four weeks after her first visit with her newborn. I watch the nurse Pat as she talks with the mother. Pat is the kind of person that exudes calm, and nothing is hurried. You find yourself relaxing just being around her. She's the type of nurse you want to be working the night shift with. You know that she can handle anything that might happen.

As usual the visit begins with the mother undressing the baby to be weighed and while she does Pat stands by her side asking how things are going. Mom and nurse admire the little girl's activity. The mom says "I'm amazed how strong her abs are. She'll put her legs straight out in front and hold them for 15 seconds. Pat laughs and says " Well remember, she didn't just have a baby" and everyone laughs together.

Next they weigh the baby. Pat does the calculations and says "She's gaining about 40 grams a day. So she's doing well." The mom sighs and looks relieved. "Good I thought maybe I was starving her"

While the baby is lying undressed on the table the mom shows Pat the baby's umbilicus and asks about healing and wonders if Pat thinks it looks normal. Pat explains how the umbilicus heals, asks what the Mom is doing to clean it, describes the normal progression of healing. As well they discuss what would be considered abnormal. The mom asks what a herniated umbilicus would look like and what she should do if it occurred.

Pat then says "How is the feeding going?" The mom replies "That's what we're here for today. We eat all the time. Just in the last 3 or 4 days, it's almost like it's the only thing that consoles her. She won't try the soother, she doesn't like the swing, she doesn't like to be carried around; it's just the nipple that's going to make her quiet. She'll drink just a little bit, then she'll play. I don't know... Pat asks "Has she had a growth spurt yet? They usually have one around 3 weeks and around 6 weeks. The mom ponders this and asks "How do you know they're doing that? Pat smiles "Suddenly their feeding changes and they want to nurse all the time"

The mom looks a little skeptical and says " Is it usually just one day? Pat replies " No, it can go 3, 4 days, even a week. The mother nods with understanding and says "Okay, maybe that's what she's doing then."

Pat notices the baby smiling and the mom laughs and says "That is the funniest thing. She smiles, she makes noises and coos away. Its like she's talking to us already". The discussion moves to the baby's wild Mohawk hairdo, to cleaning her ears and nose, to baby poop. The mom says she's been pooping a lot and having lots of wet diapers. Pat says she usually doesn't' worry about the color of poop except when " its bright green frothy poop like soap bubbles." The mom says yes that happened once. It actually kind of freaked me out, because it was just bubbling out when I was changing her".

Pat says *"Usually that happens (the changes in the poop), if they've just been kind of snacking and on and off and on and off kind of thing —*

The mom says "Yeah, that's what she's doing."

Pat continues " then they get kind of gassy and everything."

The mom laughs and says "And that's the other question we had today".

Pat continues "So all you need to do if she does, put her back on the same side and feed her longer while doing breast compression while she's feeding to try and keep the milk coming so she's less likely to pull on and off. "

They then move to the nursing chairs and the mother sits down, arranges a pillow in her lap and begins to nurse the baby. Pat, standing back watching, asks "Is that how she usually latches on for you?

The mom says "Yes, because she's been doing those sort of snacks, she'll slip off, and then she'll bite the end of the nipple. So that's not so pleasant.

Pat moves in closer and puts her hand on the babies back "I would say she's got to be turned a little bit more, mom, like that. Pat gently turns the baby's body towards the mothers torso. "There you go. This hand comes up behind here __like this [pause] Are you okay there? She does slip that bottom lip a bit, doesn't she?"

The mom "She does get on and then she starts slipping. Pat continues " In that case, bring her back, just like that. There you go. That's look better. How does it feel?

The mother nods and continues"She's normally, by now, snacking if she's hungry.

Pat watches and asks".Does she pull at the beginning of the feed?"

The mothers shakes her head " At the end of a feed. Almost like a pit-bull."

Pat winces " So be kind to your nipples. When she does that, that usually means that it's slowing down, and she wants it a little faster, so put her on the other side when she starts to do that. 'Cause that side's all ready to let down, and it'll satisfy her quickly, she won't be pulling, and she won't be slipping, and then when she's finished that side, you can always go back to the other side.

The mother nods with her eyes on the baby " Yeah, that makes total sense. I thought she was just — I don't know what I thought she was doing.

Pat asks further " So generally, she'll stay snuggled in there quite nicely for you?

"Yeah" The mother replies. Pat says " How are your nipples with all this pulling?

The mother looks at Pat and grimaces a bit " Just a little bit purple on the end, but it's kind of been that way from the beginning, because we started off with a breast pump at the hospital. Then it went away for about a week, and then a few more incidents, off and on. But it's not extremely painful." Pat remarks "Taking her of and repositioning when she smacks will help prevent more damage."

Their conversation shifts to milk letdown and increasing milk supply, to the old adage of drinking beer to stimulate milk production, to the herb sage decreasing milk supply, to flat nipples, burping, to the milk-drunk look of a satiated baby, to increasing milk supply, to nursing while trying to become pregnant, to being pregnant and nursing. The conversation easily moves across the varied terrain of topics until the mother's questions are answered. Mom finishes nursing and dresses the baby and as she leaves she says

Thanks. I come here, I think, "I've got all my questions answered. Now I'll be fine. I don't need to come back." Then it's, like, "Ah!" Something gets thrown at you and I'm back again. So thanks again until next time

Bergum (2007) said "to live as a mother, puts women in question "(p. 8). While questioning of oneself and the discourses is necessary for growth and possibility, questioning without support can also lead to doubt and worry. To often new mothers question only themselves. The paradox in our society is that "our public discourse on the subject of motherhood tells us 'everything' and 'nothing' that we need to know" (Maushart, 1999, p. 7). Despite the glut of "information" targeted and available to mothers, Maushart goes on to say that "we remain more clueless and insecure about what

we're doing and why we are doïng it than perhaps any previous generation" (p. 8). Certainly the situation Maushart describes can be described as unsettling for new mothers. The vulnerability of new mothers is ominpresent.

Mothering is for the most part a socially invisible undertaking. Mothers are overburdened with facts that can seem very removed and distant from their actual experience of mothering a baby. This deluge of information coupled with the isolation of new mothers in their homes for most of the day can result in understandable chronic maternal performance anxiety that mere facts cannot address.

Facts and information alone do very little to help new mothers move comfortably in the flux of their dramatically changed life with a new child. Cervantes' Don Quixote said "Facts are the enemy of the truth" when he declared the prostitute Aldonza, the Lady Dulcinea, the queen of his affections. Don Quixote's fools' wisdom holds true in this instance as well. Treat facts with cool detachment and they will tell us nothing. Facts taken at face value deceive us every time because as a "fact" they become far more than they than they actually are. Unprocessed facts are truth's enemy and can be welded with violent intent or may invoke an unintentionally violent outcome. One will only be served by facts when they are reprocessed – that is when they are made meaningful in one's own life and context.

The nurses begin with a simple question "what brings you to the breastfeeding centre? Such a question invites speaking from the heart. Like the nurse's question to a patient of 'how are you? (Cameron, 1992) it demonstrates the nurse's attunement to the patient's situation. It is a question that in a very deep sense recognizes and accepts there may be limitless reasons to bring them out of their homes and to the Breastfeeding Centre and each of these reasons is as valid as the next. The nurses create an atmosphere of deep and openhearted listening. They create an atmosphere the mothers recognize as benign, empathic, respectful and accepting.

Through this respect and acceptance the nurses allow the mothers to awaken to healthy, saner longings than many of the discourses about breastfeeding and motherhood offer mothers. These saner longings call to the mothers and allow them flourish in ways that are restorative and healing. To restore is to give back, to build up again, to repair, re build, or renew. Nurses

provide a counterbalance to the discourses and give back to the mothers the confidence to connect lovingly with their child and to trust that they can breastfeed. The attunement of the nurses is crucial to the mothers because of the peace and safety it provided the mothers. Attunement to the mother is therefore foundational to the nursing gesture of settling. The attunement of the nurses was also crucial to ethical nursing practice that Doane (2004) has called a personal, embodied activity. This embodied activity of nurses will be discussed later in the chapter.

Joan the nurse:

So people come in, and hopefully don't feel — well, I will say, people who come there are people who are having problems, so they're coming in with some emotional distress. They're worried about their baby; I mean, there's a really kind of negative mindset that they're coming in with, and stress.

The nurses' goal is relieve the stress, worry and negativity. They smooth the ruffled and chaotic feelings and ease the emotional distress. One nurse most descriptively labeled arriving at this tranquil interlude with the mothers - this calm Centre from which to move back into the world outside the Centre, as being settled. *" I don't let them go until I feel they are settled."*

To Settle

She is not talking of forcibly restraining mothers to prevent them from leaving but rather that the conversation stays open until a shift has occurred. The dialogue continues until the tensions that brought the mother to the Breastfeeding Centre have relaxed. The mother's arrive and after the initial weighing and measuring, move to the breastfeeding chairs to feed their baby and receive feedback on their experience. The nurses watch, make suggestions on how to position the baby to improve the baby's latch and prevent soreness, how to support the mother's own body to be comfortable while feeding, how to use breast compression to stimulate the milk flow to keep a reluctant nursing baby interested, explaining always why its recommended to do things in a certain way and our best scientific understanding to support this. All the time the nurses respond to the mothers with compassion and often tenderness.

When a nurse was asked how she knew when a sense of truth had arisen she replied:

> *I feel I have addressed most of their questions and they are different when they leave than when they came. It may not have solved things, it may not have answered all the questions, but there is that settled feeling with them. So we've connected in some way in order to go for the next 2 days, even, and then it can change again. Not very often do I feel that we haven't connected, and I find I don't end the conversation until we have. So then it's reviewing and rephrasing to see where we're not clicking and where it's not making sense, or "I'm sensing this may be too much for you today, or for you do in general, versus the next 24 hours,"*
>
> *...But also, if there isn't that common truth, it doesn't sit well with me when they leave; like, something's not right yet. I'm worried about this mom, I'm letting the next LC know I've to this gut feeling that something, whether it's an issue, whether it just needs time*
>
> *You know, the next person may not use it that way, of that kind of gut feeling. When I feel like I've covered what I needed to cover with her in the depth that I feel that I need to cover it. At the same time you're trying to hone in on whether giving her too much information. You just sort of know what right amount or right type of information too give, because if it's not right you can sense that things just aren't settled for her yet.*

What this nurse called settling or being settled is clearly an outgrowth of a sense of truth arising. She describes the connection between them that allows the mother to carry on for even a few days. Her description shows the process that assists her to co-create truth with this mother. It is obvious if she does not have a "common truth" she keeps seeking with the woman until they come upon it together. She also notes that when a sense of truth does not arise, she herself is unsettled – "something's not right yet". She worries and informs other lactation consultants to search further. Settling can not occur without this shared truth.

How is Settling a Nursing Gesture?

The term "settling" is infrequently used in nursing literature. It is most often used when discussing infants – such as "managing unsettled infants" (Don, McMahon, & Rossiter, 2002) or as a verb "settling post operative infants" (Solberg & Morse, 1991). It has been also to describe the last recovery stage of post lung transplant patients – settling down (Kurz, 2001). In a phenomenological investigation, Raingruber(2001) studied eight pairs of nurse psychotherapists and clients. A major theme she identified was the nurse "settling into the climate of the client's world" (p. 21). The nurse's action of settling established rapport and comfort with the patient.

The use of the term closest in context to the use of the nurses at the Breastfeeding Centre was by Martel (2001). She conducted a grounded theory study with post-partum mothers to better document contemporary post partum experiences. The major process she identified was Heading Towards the New Normal, where mothers reoriented towards their new lives. She identified Settling in as a supporting strategy in this process. In Settling In mothers became more secure with their newborns. They became more competent, confident and better at accommodating and integrating to changes. Unlike settling described here – Settling In was identified from the maternal perspective and focused only on the first week postpartum as the mothers left hospital to return home.

The phenomenon that the nurse described as "settled" is symbolic of good nursing care. The earlier description contains many of the dimensions of settling. The nurse watches and waits for a palpable change in the mother's demeanor. When this change occurs there is the implication that the mother feels more in control and that she is calmer, more able to carry on. The nurse insures that the mother has more knowledge, more understanding and that she has a plan and strategy to try for the next few days. Settling though, is not finite – the nurse knows that although the mother is "settled" now but this can change. As the mother in the opening vignette says "*Something gets thrown at you and I'm back again*".

Mother's perspective

They basically just explained how things were going to happen, what we could do. It was just a nice process; you just felt like you were going to get

things taken care of and your issues resolved. They were attentive, well-organized, and obviously experienced, and made me feel comfortable.

In this mother's description, there is a sense of completion, a tying up lose ends and resolution. In her words, there is also the sense of smoothing ruffled feathers and a feeling of comfort and safety. A sense that the rough edges of her issues no longer exist and balance was obtained.

I'm currently following fourth year nursing students in their final practicum in a variety of settings. One student is working on a busy surgical ward and she talked with me about a patient who was having a lot of pain when the student came on shift. Throughout the day the student used prompt pain medication, provision of a variety of comfort measures, and adjusting her strategies with this patient. The patient reported that her pain was at one out ten at the end of the student's shift. This was a dramatic change from the morning when the patient reported her pain was 8 out 10. This is another instance where the nurse diligently directed her thoughtful nursing action toward the outcome of settling the patient.

Van Manen has said "Nursing is what makes life livable". The activities of both the Lactation Consultant from the Breastfeeding Centre and the student described were both directed at making life more livable for their patients whether it be through addressing what technically is called "pain management" or assisted with a fussy baby. As a result, they both "settled" their patients and gave them a place of comfort and ease.

The word settle as a verb comes from the Old English *setlan,* which means to "come to rest"(Onions, 1966). We rest at the end of the day when are activities have been taken care of and completed. When we come to rest the frantic activities that make up much of our lives are stopped and stillness pervades. Time can slow and there is absence of unnecessary movement. Coming to rest, we sink into a comfortable repose and the cares of the world move to the background. Thus the word settle evokes a sense of relaxation and of peace.

Mother's Perspective

One time I went there, I had mastitis and it hurt, and I just saw her, and I was right away thinking, "this is going to be okay. She's going to help me". She's very warm and loving, I think she just truly cares about us.

She knows how you feel. .... She's got lots of answers to my questions.

You know whatever comes ups, she's going to make things better.

Settle also has it origins in the Middle English *sahtlen* meaning "to reconcile." (Harper, 2001). In the case of mothers attending the Breastfeeding Centre, settling can be a reconciling of discordant elements such as Ezzo's teachings. Elements that are false and grate against the mother's instincts and that may direct her away from being responsive to her baby. The nurses are always cognizant of the multiple discourses that challenge mothers and their approach of acknowledging those elements by tying the mother back to her values and back to her infant.

Reconciliation can also occur between body and mind. Often when dis-eased or ill as in the mother above with mastitis, we can begin to live body and mind separated - the objectified body and subjective mind (Frank, 2002; Sacks, 1989). What is desired in these instances is "the hope is not just for the healing of the body but for an empathetic understanding. To be seen. To be known. The sufferings of the body, hard as they are to describe, make for epic experiences" (Griffin, 1999, p. 93). Settling results from an acknowledgment and amelioration of those sufferings and epic experiences.

In some sense settling results from what Doane (2004) would call embodied knowing. The nurse's intellectual mind tells her she has covered the full terrain of breastfeeding, mothering, child safety, dealing with family members, introducing solids, dealing with diaper rash, how to connect with other mothers, where to connect with other new mothers, where to get more information, and that sage in the Thanksgiving turkey might affect milk supply. Yet she senses there is more – calmness has not yet come to this mother. So she stays – patiently, compassionately searching for what still causes still causes discomfort, or difficulty. Doane (2002) has described how ethics and moral identity for nurses are bodily as well as rational processes. Merleau-Ponty (1998) described our bodies as the first opening into the world. There are no worldless, bodiless subjects. As such our bodies are not separate from our mind but rather all cognitive processes are interconnected with our brain, our bodies and our environments. Embodied knowing acknowledges that life does not occur in isolation. Ethical practice requires nurses to be attuned to their own emotional and bodily experience.

The mother in the following excerpt describes seeking out a tranquil interlude and calm atmosphere that are part of the phenomenon of settling:

> *They are fantastic that way. And that's the one thing with Pat exudes calm. You know? No matter how — And that's the one thing that I've always found with her is that's exactly it: if you're — you can sometimes just go in there because you just need that calming "It's okay. Whatever you're doing is fine. E's gaining weight". You just need that reassurance and stuff, — the non-judgmental reassurance, yeah. And that's what I find with her that non-judgmental is — that's why I keep going back, is just because of that. [to baby] And you like her, too.*

"Settling" occurs in any pedagogical situation. As a teacher sitting across from a student and explaining an unfamiliar concept, initially there is confusion on the part of the student, the tension of uncertainty and fear. There can be a diminished sense of self as the student silently thinks "why can't I get this right, what's wrong with me?" Gradually through discussion with the teacher, the clouds of confusion clear for the student, and an "aha" begins to happen. Puzzlement and intense focus disappears from their face. The light of enthusiasm returns to the student's eyes. The body shifts from deflated to engaged. The student leans forward excited as the "penny drops" and "the light goes on" for them. There is a palpable reduction of tension in the student's body as they become focused on the new idea their mind possesses. The student settles into their new knowledge and the tensions are resolved.

The mothers' experience parallels that of a student. Initially they sit awkwardly in the breastfeeding chairs with their feet on stools. The breastfeeding chairs are raised so the moms and babies are at eye level to the nurses. The new moms hunker their bodies forward in the chair. They lean with their bodies to bring their breast to their baby. The nurses bring pillows and ease the mother to an upright position and support the infant with pillows bringing the baby to the breast. They encourage the mothers to relax their shoulders, and bring their body in a natural, comfortable seated position. As they are doing this, the nurses question, explain, listen, and watch. When the mother's say "why don't I know this?" They reassure and offer encouragement. *"You're doing great! "No mother knows it all and every baby is different, so it's getting you and your baby working*

together." "It takes time to learn about a new person. You're both adapting – it will happen" "You're doing well! No one's breasts come with a manual!" "Most people have never had any experience with breastfeeding, so how could you know?" " You can read it in a book but its very different to have a baby in your arms. It won't always feel so awkward. As your baby grows and you become more experienced this will become second nature to you."

They offer guidance – "*See how that brings the baby more in line with the nipple?" "How's that feel?" "Is that more comfortable?" "What kind of chair do you have at home?" "Do you feel supported? Don't be afraid to use lots of pillows to get the position you need. You don't want you back and neck getting sore."* The nurses show the mothers how to pay attention to their bodies and their thoughts and feelings. Their statements tell the mothers "Yes, it's all right to feel and think anything". The process of settling is a process of affirming the mothers and their lives.

Because of the similarities between settling and the outcome of "learning" in a teacher student relationship the following section of the paper will address the pedagogical relation. Bergum (2003) used Gadow 's philosophical themes to discuss the pedagogical relation. Bergum's conceptualization of relational pedagogy through the themes of embodiment, improvisation and interdependence provides a useful framework point to explore settling in more depth. In Bergum's conceptualization of relational pedagogy embodiment is seen as *being* the teaching, improvisation as *doing* the teaching and interdependence as *locating* the teaching in the reciprocal world as home (p. 122). Bergum acknowledges that the pedagogical relation itself consists of a number of relationships – that of teacher and learner, of nurse and patient and of self and the world. The next section of this chapter will cover the first two of these three themes and their relationship to the nursing actions and the patient experience of settling.

Embodiment

In Bergum's (2003) discussion of embodiment there is a focus on nurses' relation with technology and how technology is kept from directing the relationship and separating nurses from their patients and their experience. Bergum stresses that in the midst of technology nurses must "be open to touch, staying close, hearing and smelling-not only seeing" (p. 123). Embodiment is *being* the teaching. In the earlier vignette

where the nurse described how a sense of truth arrives for her – it is obvious that all of her is involved in this process. Her whole being was involved in the relationship with the mother searching for what was still needed. Searching until her body sensed a resolution for the mother. She also admitted that resolution did not always occur but when it didn't her whole being moved forward to alert other nurses that there was more to be examined and pursued in future visits.

In the process the nurse described there was little emphasis on technology, but there was an emphasis on openness, staying close, listening and hearing. This openness is evident in the following mother's words:

> *she listens to you, and she, I think [pause] she does it so non-judgmentally. I think that's the biggest thing, is she does it so non-judgmentally that you do feel understood and not preached to*

The nurses at the Kelowna breastfeeding centre function in a relatively un-technological health care world. However, a seemingly natural activity like breastfeeding is not without technology. The babies are weighed before and after feedings on digital scales that are accurate within plus or minus one gram. Mothers are sometimes encouraged to use electronic breast pumps to increase or maintain their milk supply. Occasionally mothers use supplemental nursing systems to augment the infant's intake and increase suckling time at the breast.

How do the nurses and mothers work with technology to keep their pedagogical relationship embodied and patient focused? I will begin this discussion with the act of test weighing as it is a ubiquitous feature of care at the Centre. Every infant is weighed before and after nursing to determine how much milk the infant is taking in a feed. There can be much anxiety around this test weighing as no mother wants to hear that she is not producing enough milk to meet their babies' needs. Alternatively mothers are very keen to know how much they are producing because unlike a bottle that shows the mother clearly how much the infant has taken, the ways of gauging a breastfed infant's intake are much more subtle and require the mothers to pay attention in a different way.

First the nurses instruct the mothers in how to determine whether the infant is taking enough and if they are producing enough milk. They review with the mother how many times the infant voids and how many stools are produced a day and relate this to

infant intake. *So how many wet diapers do you change a day? How many dirty diapers?* They discuss the frequency and nature of the feeds and what this information tell mothers about the babies' needs and intake. All of this instruction shifts the maternal focus from the "technologically" determined to the determined by experience. Each diaper change takes the mothers towards reading their babies cues and wellbeing and away from reliance on outside technology. The nurses give the mothers the information they need to know so they can gauge intake and infant well-being without reliance on technology.

Regarding the actual test weighing, the nurses strive to keep the technologically gained information integrated in the context of the mother's total experience. When discussing a less than thirty gram test weigh in a baby who had been gaining well, voiding and stooling appropriately, the nurse referred to the test weight saying "*Well, that's just math and this* (referring to other signs) *is life!*" The nurse's words pointed to what was more important in the overall situation – the mother's ongoing daily experience with her baby versus technology's arbitrary one time measure that was not congruent with all other signs. Here the nurse avoided falling into a "technological trap" (Bergum, 2003. p. 123) where technology directs human action. She is not denying the accuracy of the scale reading but rather is showing that neither the mother or the nurse need to yield to disembodiment or the dominance of technology. The nurse's embodiment and that of the mother can remain intact and inspirit their relationship.

Heidegger (1993), in *The question concerning technology,* identified technology as a way of revealing things that can overwhelm humans and overshadow all other ways of revealing. As humans we are challenged by technology's drive towards total mastery and dominance in all ways of our lives. However, despite technology's dominance, it's failing is that it can only reveal by reduction. That is the twenty minutes of a mother and infant snuggled together in a comfortable chair, with the baby nursing and the mother stroking the infant's hair as they gaze into each other's eyes is shrunk by technology into a static number on a scale. In the technological discourses, the output of the technology is often conflated with knowledge. The twenty eight grams of breastmilk identified by the technology of test-weighing is made powerful simply through the means of its creation. The language used to described technology often reinforces this power. The nurse in the above situation could have stated the important data in the above situation as twenty eight

grams of breastmilk after feeding on one breast for twenty minutes. Certainly the numerical reporting is briefer than description above but also less meaningful.

Further Heidegger says of technology's results "Who would ever deny that it's correct?" (p. 312). Yet the correct only "fixes upon something pertinent in what is under consideration" (p. 312). The "something" in the above sentence is crucial, for it highlights the flaw in technology. The flaw is technology's need to limit to "something" and its inability to deal with "everything" or even "somethings". The evocative picture of mother and child portrayed at the beginning of the paragraph is lost in the technological output report. Technology's only mode of operation is to reduce, to make smaller, simpler and more manageable. Heidegger goes on "For that reason the merely correct is not yet the true." (p. 312). Thus he acknowledges that truth and knowledge requires much more than simple correctness or accuracy.

Improvisation

Using a musical metaphor Bergum (2003) relates the improvisation of jazz musicians to the *doing* of teaching. In improvisation there is a necessary ongoing responsiveness in the interaction. As one musician shifts so do others and the music and the musicians change. In improvisation, as in life, no experience exactly replicates another. Further, there is no one in final control in improvisation or in relational teaching moment – each player is attending to the other and the situation. What happens in an improvisation cannot be predicted. The improvised and contingent is also present in the relation of nurses and mothers. The responsiveness of the nurse and open nature of the interaction is evident in this mother's comments:

> *I don't know how to describe it, but I feel really, really close to her in some sort of way. I feel (long pause) ..... I feel like I could just go up to her and say whatever I feel, and she would be there, helping me and sharing what she knows. I just feel I could say anything.*

This mother's words speak to what happens in the relational space and the spontaneous interplay of the nurse to the mother. The mother can say anything (take the melody anywhere) and there is the implication is that the nurse would be there – following, sometimes leading and sometimes keeping the melody going and sometimes helping the melody grow and expand in new directions. The conversation would not run

to an end due to lack of a script – rather in this relational space where improvisation can occur the outcomes come from "sharing a lived life" (Bergum, 2003 p. 126).

Settling is an outcome of the improvisation and sharing their lives. The nurse cannot apply a standard careplan for sore nipples and be assured that the mother and baby will leave the Breastfeeding Centre feeling settled. As noted in the earlier vignette when the nurse describes the arrival of a sense of truth, the assessment process she goes through to insure the mother and babe are settled is very much an improvisation. So from the nurse's perspective its "I'm hearing this – I respond with this and now what where does that take us?" Like musical improvisation there is a continual reciprocal shifting and balancing to coordinate and create. Although there is a form and content shaped by the nurses' knowledge and their skills and competencies, there are never predictable outcomes. Thus the Breastfeeding Centre is also a place of improvisation and as a result becomes a place of possibilities where discourses are challenged and where relationship is primary. In the improvisation of nurses and mothers at the Breastfeeding Centre, the tensions of the conflicting mothering and breastfeeding discourses are ameliorated and settling can occur.

In jazz improvisation there are also times when the all the music falls away and there may only be one musician keeping a beat while the melody has disappeared. Yet eventually the music starts again and the responsive interplay continues. This also happens in the process of settling. The mothers learn that things falling apart do not constitute a disaster – rather the natural course of life is that things fall apart and start again and one can move onward over and over. Further life carries on, just like in the improvisation, and moves creatively forward.

The responsiveness that is central to improvisation is in direct contrast to the control advocated in Babywise. In Babywise, it is technology (the technique) that directs action and comes between our natural human responsiveness to each other. Parents are not to respond to their child except in ways sanctioned by Babywise. In Babywise, the dominating nature of technology is allowed to rule and overwhelms humans and all other possible ways of revealing (Heidegger, 1963). In Babywise the direction, the solution, the answer has been divined prior to the initiation of any human contact. In contrast at the Breastfeeding Centre it is human contact that directs and guides the response.

Humanity has priority over technology. Improvisation, like the nursing gesture of settling, can only occur through human to human responsiveness.

Interdependence

The final component of the pedagogical relation interdependence, will be discussed in the next chapter under the contributions of breastfeeding to understanding.

Interlude and Reflection

This study is concerned with how a sense of truth arises, rather than what truth is or what is true. The symbolism of Whatever Works in Your House and the concept of a hermeneutic space was used to capture and symbolize, the conditions under which truth can be discovered and evolve. These conditions cannot be separated from truth itself. There can be no truth for individuals without context. But when this context is acknowledged and brought forth and worked with, the outcome can be positive. Settling or becoming settled can be the outgrowth of seeking truth.

Sukha is Sanskrit word that is often translated as "happiness". It is also used to describe the place where you contemplate happiness or joy. In this respect, sukha is has also been conceived of as being a "good space". The creation of a hermeneutic space at the Breastfeeding Centre, can be thought of as sukha – a good space for mothers, babies and nurses. It is a space where the possibility of contentment, joy or happiness is opened and brought forward. It is a space where dis-ease can be attenuated, where anxiety can be quelled and learning and growth promoted and celebrated. The Breastfeeding Centre is a space where truth can arise and the mothers can settle into their mothering.

Invocation to Kali

It is time for the invocation:

Kali, be with us.

Violence, destruction, receive our homage.
Help us to bring darkness into the light,
To lift out the pain, the anger,
Where it can be seen for what it is—

The balance-wheel for our vulnerable, aching love.
Put the wild hunger where it belongs,
Within the act of creation,
Crude power that forges a balance
Between hate and love.

Help us to be the always hopeful
Gardeners of the spirit
Who know that without darkness
Nothing comes to birth
As without light
Nothing flowers

May Sarton (1993) p. 326

May Sarton was a prolific writer and gardener, who wrote into her eighties. She was known for her humanness, her diversity and her balance. The above is a brief excerpt from the poem "Invocation to Kali". Kali is the Indian goddess both of destruction and of creation. As such Kali is thought to represent the rich fullness and complexity of life. That one Goddess can represent what are commonly viewed in the West as irreconcilable dimensions, shifts one's thoughts away from traditional dualistic perspectives. In this concluding portion of the poem Sarton invokes Kali's assistance for all of us in our search to balance what may appear as opposing dimensions of our lives.

I include this excerpt from the poem because it evokes what I experienced as I watched and participated in the practice of the nurses. The nurses dealt with both destruction (emotional and physical discomfort and pain, frustration or discomfort) and creation (nurturing a new life, nurturing the relationship of the new mothers with their babies towards new possibilities). Although motherhood is more often acknowledged as a duty, as natural, or challenging it is rarely labeled creative. Perhaps our traditional discourses overemphasize a prescriptive orientation to mothering with the result, creativity doesn't feature in our narratives about motherhood. Yet motherhood begins

with the creation of new life – the most magnificent, magical and mysterious creation that is humanly possible. Connie Kaldor, a gifted singer songwriter, has called motherhood her most creative act. However she wins few accolades for her mothering. It appears we have lost reverence for this creative act and the mothering that flows from it.

Further the Breastfeeding Centre can be a place where things can be seen for what they are. It is a place where the discourses as seen as just that – stories about the world that are not truer or more relevant than the mothers' and nurses' experience. The Breastfeeding Centre is a place these stories and the emotions that they engendered can be balanced in the mother's vulnerability and love for her child. Through this balancing the mother can create her own and her child's future. Through this balancing of darkness and light, pain and frustration a mother can become settled and still.

Using Sarton's gardening metaphor the Breastfeeding Centre nurses can be thought of as spiritual gardeners for the mothers. They are spiritual in the sense of spirit inspiring.

The word 'spirit' comes from the same roots as words we use for breath. We inspire when we take in a breath. When we expire, we breath our last, we die. That is we literally give up our spirit, our breath. Our breathing in and out is the process called respiration. When we teach breathing techniques for childbirth, we are reminded that breathing is a two-way process. If we only breathe in one direction and we lose the trigger to breathe in, we hyperventilate. Spirit and breathing relies on the dynamic relationship between inspiring and expiring. In the pause between inhale and exhale stillness, peace and clarity can be found. When we exhale and inhale the world and our perspectives on it can be enlarged.

To inspire is to breathe and emanate energy. To inspire is to move life giving breath and energy through the body. The nurses inspired by breathing life into new possibilities for the mothers. The nurses also assisted the mothers to breath into what existence placed before these new families. The nurses denied no part of the life of the mothers, and they stayed, and stayed with what was happening. In a sense the nurses "breathing" and staying with the mothers brought the mothers back to their bodies and back to themselves. To breath together leaves the past behind and lets the future come as it may. The nurses' calm abidance during each visit led to a sense of tranquility for the

mothers. Just as gardeners walking through their gardens succumb to an intangible beatitude that takes them for a brief escape into another dimension, a visit to the Breastfeeding Centre serves a similar function for the mothers. It provides the mothers with an opportunity to settle and find peace.

The other descriptor that Sarton uses is hopeful. Hope is central is to the process and outcome of settling. Hope is an outcome of the connection and hermeneutic space created at the Breastfeeding Centre. Hope arises out of the sense of possibility that this space engenders.

As a passionate gardener the following words of Sarton resonant for me:

Who know that without darkness
Nothing comes to birth
As without light
Nothing flowers

"Hopeful gardeners of the spirit" know that both darkness and light are the givens and necessities of our lives. It follows that as darkness and light are fleeting and transitory, the only constancy is that things will change. Awareness of this allows the gardeners (nurses) not to fight against darkness and elevate the light or vice versa, rather each is accepted. It also knowledge of this evolving and shifting background of darkness and light, that allows one to be hopeful and carry on.

I will end this section with some personal mottos that have arisen from my years of gardening. From my personal experience, I believe that gardens are *sukha* – a good space. Sarton's writings further support this belief about gardens. Like the Breastfeeding Centre, gardens provide a good space where one can learn and grow. I include the mottos here because they also appear applicable to the work of the nurses as gardeners of the spirit. These mottos evoke the understanding and wisdom that the nurses possess.

Gardening Mottos

If It Doesn't Work Try Something Else

As a gardener we have visions and ideas of a paradise or cathedral that we wish to create. However, the dwarf spruce you planted in front of your window grows to 40 feet, there is either too much rain or not enough, there is a hail storm the day before you get to harvest the year's bounty and the plant guaranteed to grow anywhere succumbs despite

your tender ministrations. So gardeners learn that despite our valiant and repetitive attempts – not everything works out as one might hope. The recourse is to then try something else.

Nurse perspective

> *So it's a constant evolution, the plan, because parents are changing their perception of things as they go along, and you try you best to come up with different plans and changing as you go. So it's not just a baby, a weight and how much the intake is. It's important to let them know that we're* going to <u>try</u> *to do this, but it might not work. But then you reassure them you can try something else.*

The nurses were very aware that there are no sure solutions or one size fit all process that would guarantee a desired outcome. They would however present options and the parents would decide what options would work with their lives. As the nurse said they would work with the changing perceptions of the parents and adjust their suggestions accordingly.

Life is Fragile, Protect It

Gardening reminds us of the fragility of life. We plant a hundred seeds but only reap a few struggling plants. We place our tender perennials out late in June and we get snowfall the next day. Gardening reminds us that nothing can be taken for granted. Every component of our garden needs some care and attention to thrive.

The nurses spoke of the fragility and also the opportunity that existed in each new family. The families wanted so much to parent well and the nurses worked to protect and nurture every effort the parents made. Much like gardeners make extra effort to nurture seedlings so did the nurses nurture these new parents.

One nurse spoke of the recent extension of maternity/parental benefits to a full year postpartum. She saw this as acknowledging the fragility of family life and doing something to protect and assist families.

> [Speaking of the previous six month maternity leave] *What a horrible, horrible thing to do families. But if you can get a baby to a year who has had that wonderful opportunity to bond with his caregivers, whomever that is, and then be able to go out into the*

world. What a dynamic that changes- better than all these harried families we see. That probably is going to help society more than anything I can think of.

Life is Enduring, Trust It.

Gardening provides many lessons in hope. What I've learned from gardening is that there are almost no fatal mistakes and very few serious ones. You always have the chance to start over. Hope is nurtured by being in the company of trees and plants and flowers, by witnessing the relentless strength and energy of growing things. Gardening requires the ability to cultivate a relationship with the unknown, to create a form of friendship with what lies around the corner, on the horizon, with those things that have not fully come into being. Hope and trust go hand in hand.

Families like plants are resilient and stronger than one might imagine. Consider the young teenage mom discussed in the section on weaning discourses, despite the challenges of her youth, she had successfully parented and established a very lovely and responsive relationship with her child. The nurses trusted in her ability to do well and excel and she did.

Growth Takes Time.

There is much that the garden teaches. I have learned to wait and to be patient. I have to do my job and then wait on the season and wait on the natural progression of growth.

The nurses had a similar patience. They saw that every positive action that built the relationship with a new mom and her family as worthwhile. They often said that unlike acute care nursing – you may not know for years whether your nursing had made a difference.

Life is Daily, Water it, Weed it.

Some gardeners love to wrestle with the elements, digging into the soil, moving rocks and boulders, planting and replanting. They are the artists and engineers of the garden: they thrive on the challenge of turning bare ground into something lovely and fruitful. Other gardeners are the nurturers, who love to attend to growing things the way they attend to children. Either way you can't be involved with gardens long before you realize that as much as you are growing them, they are growing you. Teaching you.

Making you wiser. I've learned to appreciate the process of gardening as much as the product of my efforts. And I'm coming to appreciate the lessons my garden can teach me when I pay attention to it – when I water and weed it. There is an abundance in the process never dreamed of in the planning.

Nurse perspective

I think when you build that trust, they'll come back to you. I've been around long enough that I'm seeing the first babies I worked with go to kindergartner and school. I'm seeing these moms with their second or their third baby – they seek you out. You know if you build that trust and it's such a privilege to see these women and babies grow.

CHAPTER EIGHT

THE NOTABLE CONTRIBUTIONS OF BREASTFEEDING TO UNDERSTANDING

What is Held in the Space of the Breastfeeding Centre?

In earlier sections of the dissertation the conditions and elements at the Breastfeeding Centre that coalesce to create a hermeneutic space where mothers and nurses understand and make meaning of their experiences of breastfeeding are described. The final section of the text focuses on the Breastfeeding Centre as a space where the participants acknowledge and revere the notable contributions of breastfeeding to mothers and infants, to our communities, and to society. This examination of breastfeeding is my attempt to reveal the notable and substantive contributions this phenomenon can make to understanding. Breastfeeding can about teach us living, growing reciprocal relationships in constant renewal and transformation and ultimately about what it means to be human in an interdependent world.

What are the notable contributions? How might they be best understood? What can be learned from them? The following discussion will focus on three contributions illuminated in the breastfeeding relationship. Breastfeeding is an exemplar of: 1) interconnection and intimacy; 2) embodied knowledge; 3) a creative, intuitive, ecological and relational experience. There is an undeniable connection between mothers and infants when breastfeeding. Further we are caught and draw towards the physical and social presence of infants who can remind us of the mysterious soulful nature of life itself.

The subject of the lactating and nurturing breast has for the most part been absent from public view. There few images of healthy breastfeeding women circulating in the Western popular culture imaginary. For the most part breastfeeding has been relegated to the private enclaves of women's everyday lives. The images that circulate tend to problematize breastfeeding – e.g. women who choose to breastfeed in public (Bartlett, 2002b; Cushman-Dowdee, 2004, p. 127, 2007) or those having difficult feeding. Bartlett (2002) states our current breastfeeding discourses (e.g. Ezzo) "tend to position women as problematically unpredictable and in need of management" (p. 373). Thus women, babies and their relationship are problematized and the dominant religious, medical, social, historical, economic discourses discussed in Chapter Four remain unchallenged. Further the revelatory potential of the breastfeeding relationship remains largely

unexamined. "Although breastfeeding is not a part of many people's lives and it is only an incidental part of those who breastfeed or were breastfed, breastfeeding as a deeply contested and cloistered space is rich with imaginary possibilities." (Giles, 2003, p. xv)

"The customs of the maternal world are generally ruled by proximity, but a proximity unthought as such." (Irigaray, 2002, p. 19). The following is my attempt to think about one proximity of the maternal world, that of breastfeeding. I plan to show that an examination of this proximity and its resultant outcomes can enlighten our understanding.

Philip Simmons (2000), author of *Learning to fall,* reflecting upon the inadequacy of viewing life as a technical difficulty or problem stated:

> For at its deepest levels life is not a problem but a mystery. The distinction, which I borrow from Gabriel Marcel, is fundamental: problems are to be solved, true mysteries are not. … Each of us finds his or her own way to mystery. At one time or another, each of confronts an experience so powerful, bewildering, joyous or terrifying that all our efforts to see it as a "problem" are futile. Each of us is brought to the cliff's edge. At such moments we can either back away in bitterness or confusion, or leap forward into the mystery. And what does the mystery ask of us? Only that we be in its presence, that we fully, consciously hand ourselves over. That is all and that is everything. We can only participate in the mystery by letting go of solutions. This letting go is the first lesson of falling, and the hardest. (Simmons, 2002, p. xiv)

The experiences of breastfeeding and mothering can be an experience as Simmons describes above. Breastfeeding can simultaneously and alternatively be powerful, bewildering, joyous and terrifying. As such, breastfeeding can be an experience from which mothers back away in guilt and confusion. It can also be an experience directed by directed by rules and schedules and stripped of its mystery. Yet breastfeeding can also be entered into. If entered, it can be an experience that requires mothers and infants to leap forward into the mystery. The call for approaching parenting as mystery was raised earlier in the Babywise discussion in Chapter Six. In this current section I will attempt to illuminate the potential understandings that inhere in the mystery of

breastfeeding. What can we learn standing in the presence of breastfeeding? What can breastfeeding show us about life, living and truth?

Excerpt from *The angle of repose* by Wallace Stegner

With the dried, talcumed, wrapped and fretful weight on her shoulder, protecting the little warm round head with her hand, she stooped and blew out the light. In pitch blackness hung with afterimages of the lamp's flame, a cloud of green moons the shape of ragged smiles, she found her way back to the other room. By the time she had located the rocker and sat down and opened her nightgown to let him nurse, she saw the darkness had become dusk. The windows were gray, the furniture had acquired substance, the wallpaper all but revealed its pattern. Oliver's face, down in the pillow, had one ear, one closed eye, half a mustache.

The baby's sounds were so hungry he reminded her of some dry root in the first rains; her breast was wet and slippery with his mouthing. Creation, she thought. Emergence. Growth. Already he was a person, with his fat legs and his firm mottled flesh and his toothless smiles. He had never had a day of sickness. Not so much as a cold. She was determined he never should. And he didn't weight eleven pounds at birth, that was an insulting error of Dr. McPherson's scales. Oliver, figuring backward along his normal rate of growth, had estimated that he couldn't have weighed more than eight pounds. Yes, she told him, bending down to nuzzle his silky hair. Yes, but! You eat like that and you'll weigh as much as Mrs. Elliot's horse.

....The baby sighed and slobbered at her breast...

He hung from her breast like a ripe fruit ready to fall. His eyes were closed, then open, then closed again. When she detached him milk bubbled over his chin, and she wiped him off, scolding him for being a piggy. He threw up so easily, not like a adult covered with cold sweat. His wasn't sickness at all, things came up as easily as they went down. It was as if he was still used to the forward and backward flow of his mother's blood washing his food into him the way the sea washed food into an anemone on a rock. And her blood still remembered him: Was it perhaps his hunger that had awakened her this morning, and not his

cry? She hated the thought that he must become a separate, uncomfortable metabolism cursed with effort and choice.

(Stegner, 2006, pp. 178-181)

Creation. Emergence. Growth. All motherhood is grounded and shaped by these forces. Breastfeeding, as a component of motherhood, links back to these core experiences. Creation has it roots in the Latin word *creãtus* meaning to bring forth or cause to grow (Onions, 1966). Emergence has it beginnings in the Latin word *emergere* with the earliest meaning of "come to light, arise" (Onions, 1966). Creative works hold surprises and teaches things we did not know. Creative work helps us unfold and become who we are and allow others to become.

Present in all the above words is the inevitability of change and movement. In the acceptance of this inevitability exists the possibility of broader, more fruitful perspectives and the possibility for generativity. Creation, emergence, growth. The words capture the key characteristics of all natural elements, they are created, they come forth, grow and change. It is an inherent part of creation to produce new forms. "Creative work that makes something new from the paradoxical combination of focused intent and a willing surrender to something larger than us, creative work that necessitates conscious purpose and expansive receptivity, will and grace" (Mountain Dreamer, 2005, p. 7)

Yet creation, emergence and growth do not exist in a vacuum. They are all experiences shaped by connections and contingent on the environment in which they occur. These phenomenon cannot exist as an independent and individual trajectory or project - rather they are phenomenon that occur in and through relationship with others, with society, and the environment, both man made and natural. Creation, growth and emergence for humans are necessarily relational phenomena.

Breastfeeding as Connection

There is an undeniable connection between mothers and infants when breastfeeding. Further we are caught and draw towards the physical and social presence of infants that can, if we allow it draw us into mystery. Breastfeeding, although an incredibly complex physiological, psychological and interactive process, can also be incredibly simple. As simple as mother and infant giving and receiving, each dependent on the other. The grounded pleasure of infant and mother joined together in their

becoming. Despite breastfeeding's simplicity, there is much that is unknown and unshown, until the experience of breastfeeding is lived.

Breastfeeding provides a connection that resonates on many levels. It is a connection that is physiological, psychological, emotional and spiritual. Stegner (2006) captures this unique connection in his words: "*It was as if he was still used to the forward and backward flow of his mother's blood washing his food into him the way the sea washed food into an anemone on a rock* (p. 181). These are not separate beings but beings inextricably linked and joined in an awe-inspiring fusion. Our ideas of boundaries are challenged by this vision – where does the mother end and the baby begin when their very corporeality is joined in this manner? *"And her blood still remembered him: Was it perhaps his hunger that had awakened her this morning, and not his cry?"* The connection Stegner describes is not one sided –rather both mother and child are so irreducibly linked that she felt his need for food in her blood. Stegner's description of this relationship repudiates Western society's tendency towards individualism and separation. Whether we take his description literally or not, the words are illustrative of the deep interconnections between mother and child. The description defies us to take actions that would prematurely sever or alter this relationship.

Bergum (2007) also describes the interlocking of the mother and child through their bodies and through relationship. "Through the experience of pregnancy, quickening and nurturance, the mother turns toward the child and back toward herself; and in that experience of turning she creates a moral space, a Third-Space, for the relation itself to develop. (Bergum, 2007, p.7). I postulate that breastfeeding is a re-creation of the "love space of the womb" (Oenning-Hodgson, 2007), or this Third Space mentioned above (Bergum, 2007).

To be pregnant is "to be with child" and unlike most instances when we describe being with someone – it is not the autonomous but near sense of closeness. Pregnancy requires and actual interconnection of physiological systems, the exchange of nutrients from the mother's blood. There is a symbiosis between mother and child- each affecting and influencing the other physiologically and experientially. Wynn (2007) has described this as a chiasmic relation. "Chiasms, which are nonpossessive, are reversible, characterized by a mutual crossing over and withdrawing back into individual

particularity (Merleau-Ponty, 1968, p. 266), and are distinquished by the independence of both sides" (p. 68). These chiasmic relationships are continued during breastfeeding. Neither mother or baby is passive in this relationship. Wynn goes on to say that "their relating is instead a richly textured, co- created, active intercorporeal interplay" (p. 68).

Breastfeeding in its continuance of the mother and baby symbiosis of pregnancy, of two who were once one, provides a prototype for a mutually supportive and ethical relationship. Oenning-Hodgson (2007) evokes the symbiotic ethical pregnancy relationship in poetic terms:

> The relationship pattern is a flowing, primitive, rhythmic dance between three spaces, the mother, the baby and the Third space, where these two separate spaces merge where nourishment flows through blood and breath from one to the other, where separateness and togetherness are not contradictory. Instead separateness enables togetherness."(p. 49).

The mother by offering her breast to her child is offering her love and turning towards the child. We tend to think of humans as having one body in this life, a body separate and defining. Yet in reality we all began as part of another body, which also began as part of another body. To reflect upon this reminds of the continuity of human life and the corporeal connection of humans to one another like a ribbon running through eternity. This connection grounds us in our common humanity.

Further breastfeeding allows the baby "a slow weaning from its other body" (Erdrich, 2005, p. 5), that of its mother. When asked why she enjoyed breastfeeding one mother replied:

> *It was because I'm was the only one that can meet my baby's needs in that way....When my mom and dad were here, and my brother lives with us and my husband, they all look after her, but then when she's hungry, it's "Mommy! Mommy!" And then when I was feeding her, she would reach out and touch my face, you know just the two of us together... a closeness... because when she was in my tummy, when she was kicking, I would know there was someone with me all the time, and now that she's out, it's just that I sort of crave that feeling - I miss her – So when I feed her and she touches me and grabs my face – I still have that.*

For this mother, breastfeeding allowed a slow weaning of the mother from her other body, the body that shared her nutrients and relied on her breath to maintain life. There is mutuality in their shared need for slow weaning and in the connection of the mother and child. Both mother and child are nurtured by the connection – the mother's words demonstrate the depth of the connection as well as the emotional sustenance than she received from this breastfeeding relationship. Breastfeeding allows more gradual differentiation of what was "one yet two" delicately intertwined beings into distinct yet deeply connected individuals. Both grow physically and emotionally because of the connection. The connection between mother and child grows as well. Reflection upon the meaning of this connection can further contact us more deeply to all of humanity. It is not just this mother and baby sharing and intimate but mother and infants for millennium who have shown us the wholeness of live and meaning of connection.

This slow weaning process for mother and infant, however, does not represent resistance to change or progress. As mentioned earlier childrearing is about creation, emergence and growth all of which necessitate change. Breastfeeding also shows us the constancy of change. On a daily basis the mother's body responds to the infant's body adapting breastmilk production and characteristics as the child grows. The amount and type of milk produced and even the nature of the feeds changes with the baby's growth and maturity.

Breastfeeding can also teach us about the connection necessary in ethical relationships. Bergum and Dosseter (2005) cite breastfeeding as one of the earliest experiences of engaged interaction (p. 115). It is a relationship that is mutually beneficial for both mother and infant. As the infant suckles and is supplied with milk, the mother's hormones are stimulated. These hormones as well as releasing the milk supply, assist the mother to relax into motherhood. Bergum and Dosseter note "this is an abundance paradigm, where the more one receives the more one is able to be involve and grow" (p. 115). So breastfeeding can teach us about relationships that replenish both partners. Breastfeeding can also remind we are not isolated, nor independent, rather we are always connected to one another.

Taylor (1991b) identified individualism as one source of worry or identified decline in the "development" of civilization. Individualism is worrisome because we

have lost seeing ourselves as part of something larger. Hierarchy, although restrictive, gave meaning to the world and to social life. With the loss of a rigid ordering we have lost along with it the sense of some greater purpose – resulting in self-absorption to the detriment of contemporary society. As result we have become disenchanted with the world. Although individualism has brought recognition and protection for the individual, it has not been without consequence. "The dark side of individualism is a centring on the self, which both flattens and narrows our lives, make them poorer in meaning, and less concerned with other or society" (Taylor, 1991b, p. 4).

Certainly a society where we cannot see the other is problematic. It challenges our very humanness. We simply become consumers with little regard for our fellow beings and the world around us. Breastfeeding and mothering (Bergum, 2007) provide a counter to this a vision of humanity that is narrow and self-centred and without a greater purpose. Bergum identified that the "way of the mother" (which includes breastfeeding) can teach us much about moral and life-affirming stances and purposes.

Breastfeeding can be seen as a prototype for unfettered intimacy in connection. To be intimate has a variety of meanings – closeness as in friendship or sexual relations. Alternatively, intimacy can refer to one person - to something that is deeply private or personal. Perhaps this why people have such strong reactions to breastfeeding – it taps into something deep, personal and private and people feel uncomfortable. The original meaning of the word intimate – was to know or make known and can pertains to the essential structure or intrinsic nature of something. All of these meanings are present in the experience of breastfeeding.

A colleague, who describes herself as passionate about breastfeeding and who breastfed her oldest until he was three years old and her youngest until two and half, recounted the following story.

> *She was seven months pregnant with her second son and sitting in a chair nursing her toddler. As she was gazing into her toddler's eyes and stroking his hair while he contently nursed, her fetus gave a strong kick. At that moment she was overcome with emotion – first with a great sense of intimacy, love and connection to both her children. Then with a feeling of sadness and poignancy as she thought "I will never again be this close to my two children"*

At that moment she described, she was with her two children, one an internal being, the other external, in probably the closest ways humanly imaginable. Wynn (2007) has described the pregnancy and early mother-infant relationship as "characterized by intense proximity and sustained bodily involvement never likely to be matched again in a lifetime" (p. 69). Thus this mother, although nursing a toddler rather than an infant, had the uncommon experience of simultaneously experiencing the intense proximity and intense bodily involvement with both her children. Her sadness and poignancy came from the realization this simple, intense and uncomplicated closeness with both children was rare. Further that this type of physical closeness would be short lived in her life as a parent, as her children emerged and grew. It was a bittersweet time as a mother who welcomed her children's emergence and growth and yet at the same time knew she would grieve the simplicity and uncomplicated nature of this intense and profound connection.

Fiona Giles (2003) in her book, *Fresh Milk*, a compilation of stories and results of questionnaires about the attitudes to breastmilk, asks the reader to broaden their thinking about the meaning of breastmilk in our lives. Here is her own story about her first child born five weeks early.

> He sweated from the effort of latching on, and would stop every few seconds, his chin trembling as he mustered his forces to continue. He soldiered on in a way that I notice he soldiers on even now, as he learns to read and write. Breastfeeding was his first lesson in the fruits of persevering.
>
> But there was more to it than this physical challenge that consumed us both. I was also fascinated by the continuing symbiosis of our bodies, as mine adapted and as his grew, and the unique relationship that breastfeeding encompassed. Breastfeeding demonstrated the real meaning of intimacy, which when used as a verb, to intimate, means to make known. Bottle-feeding reduces the opportunity for a baby "to make known" its needs and personality, substituting a series of measurements calculated by the parent alone – milliliters of formula, parts of water to powder, scales for baby weighing, and four-hour segments of time, if the feeding is based on a schedule. Breastfeeding, especially when offered at the baby's request, requires close attention to opaquely expressed feelings-hunger, tiredness, pain, distress, playfulness, even boredom. It requires intuitive reading

of needs, and the subtle art of registering their fulfillment in mind and body. (p. 243)

Giles' words "Consumed us both" words imply that you are eaten whole –eaten together – gobbled up as it were by breastfeeding and being breast fed. The breastfeeding experience does not lend itself to dabbling on the surface, nibbling around the edges of experience. It is an experience where both mother and child are drawn in, transformed and changed in the process. This is a relationship that must be entered into, deeply and fully. It is difficult to successfully breastfeed by a superficial immersion in the experience. To change the analogy, to breastfeed one cannot stay in the wading pool, testing the waters with your toes. Rather it is an experience where the participants are plunged into the deep end of the pool of sometimes cold and icy water.

The responsive type of breastfeeding Giles describes above, allows the development of unique intimacy between mother and child. It is an intimacy that requires a paying attention and responsiveness. Breastfeeding provides an intimacy born of interdependence and commitment, yet not devoid of pleasure:

> The intimacy of breastfeeding also rests on the mutual pursuit of pleasures: the languorous play of tongue and lips, the sweet mingling of warm fluids, soft flesh, and comfort, as need and contentment are held in perfect equipoise. As Freud famously pointed out, 'Sucking at his mother's breast has become the prototype of every relation of love." Adrienne Rich put it more simply in her poem "To a Poet", where she writes, "Small mouths, needy suck you. This is love. (Giles, 2003, p. 242)

Breastfeeding as the prototype of love and intimacy is a mutual, uncomplicated giving and receiving. It is a giving and receiving freely and without reservations. Mutuality and synchrony (Hartrick Doane & Varcoe, 2005), the sharing of commonalties and bridging of differences, are central to the intimate relationship of breastfeeding. Mutuality and synchrony remind us that relationships are not formed, they are lived. Every moment of breastfeeding occurs in-relation.

Breastfeeding and the Presence of Children

As humans we are caught and drawn to the physical presence of infants.

> I realize that there is nothing more astonishing than the human face.... It has something to do with incarnation. You feel your obligation to a child when you have seen it and held it. Any human face is a claim on you, because you can't help but understand the singularity of it, the courage and loneliness of it. But this is truest of an infant (Robinson, 2006, p. 66)

The speaker in Robinson's novel Gilead speaks with reverence of the human face. The face captures and represents all that is human. The face of a child is an actual embodiment of the mysteries of life. It speaks to recognition of the isolation that being human can bring but also indicates that this realization can draw us together. Levinas (1985) also spoke of the vulnerability of the human face and says the "access to the face is straightaway ethical" (p. 85). Thus the human face, especially the infant face can call us to a commitment – deep and rich.

Levinas (1985) said "Face and discourse are tied. The face speaks. It speaks, it is in this that it renders possible and begins all discourse" (p. 87). It is the face that draws forth a response and it is with our gaze into the face of another that an authentic relationship begins. Bauman (1993) has described the 'primal scene' of morality as existing in "the realm of 'face to face'...This is where morality begins; morality has no other beginning, all other claims to paternity being presumptuous or fraudulent" (p. 110).

Speaking of children in the classroom, Smith states what children request from adults "a certain direct authenticity, a sense of deep human resonance" (Smith, 1999a, p. 139). I suggest this is what all humans seek and strive for – authentic interaction to resonant with another's being. The descriptions of Stegner (1971), Giles (2003), Erdrich (2005) and the breastfeeding mothers quoted above evoke reverberations of human connection and meaning. Breastfeeding can show us how life is lived together and how difference is negotiated – in deeply connected pairings that ebb, flow and change but always strive for possibility.

Breastfeeding takes us back to our beginnings, to our ground and our foundation. We too were small and vulnerable – we too still rely on others. Breastfeeding can be the archetype for a "better life that is richer, deeper and truer in its interconnections between persons" (Smith, 2000, p. xiv).

The following vignette forms the basis of discussion for the final two contributions of breastfeeding that I wish to discuss: exemplification of embodied knowledge and of a creative, ecological and relational experience. Below is an account from the mother of a baby who was premature and who had been unable to nurse most of the time he had been in hospital.

> *This is like my fascinating story, my amazing baby. He was only — he'd only been home, what, a few weeks he was, he was only a tiny baby. And I was lying in bed with him, so I'd just started breastfeeding, trying to do as much as possible. But he's in bed with me, just got a diaper on, and I'm naked. And he's lying on my belly, and he's only tiny, tiny. And he starts doing this wriggling around, and I'm watching him, and I just — I'm lying back like this, and I'm just thinking, "I'm just going to watch what he does." The absolute truth, this baby inched his way up my body — this is a baby that can barely move or do — inched his way up my body, got to my breast. Gradually. So he gets up here, and he's, like — and he lifts his head — and he's so weak — and he lifts his head and brings it down [both laugh] and he lifts and he keeps trying and he keeps trying and he keeps trying, and he gets on. Anyway, some attempts later, he latches; he gets on, he latches, he starts to suck, he has a feed. As he's feeding, I'm crying [both laugh]. The other boob is leaking, and I've never had a boob that leaked, and my boobs have never leaked. I've got a million breast pads, and I've never used them cause I never leaked. And I'm overwhelmed; it's just an amazing experience. This baby's just latched, and I'm crying, the other boob is leaking, and he has a feed. Latching him on was so hard! He can do it on his own, for God's sake! He's like a little puppy or something*
>
> (underlining added to reflect mother's emphasis)

Embodied Knowing

The body has been a rich domain for theoretical discussions. Critical social theorists such as (Foucault, 1995) have contended individuals' experience of their bodies are tied to their social power, worth, rights and privilege. Rich (1986) similarly described the body as a politically inscribed entity when she suggested that the "repossession of

women of our bodies will bring far more essential change to human society than the seizing of the means of production by workers" (p. 285).

Rich's statement reminded me of the line in James Joyce's "A painful case" (Joyce, Scholes, & Litz, 1996) "Mr. Duffy lived a short distance from his body" (p. 5). The sentence is evocative –first the image catches one short and makes you smile. Then the realist thinks that's physically impossible to live away from one's body but the words also evoke clearly the type of person that Mr. Duffy is. For Mr. Duffy to live a short distance from his body is to be completely and irrevocably disembodied. Rich's statement speaks of the disembodiment of women but also of the social, historical and economic reasons women aren't in control of their bodies.

Bartlett (2002), in her examination of the lived bodily practice of breastfeeding, notes that breastfeeding as it typically represented is largely a matter of headwork. "The tensions installed between breast and head .. overwhelmingly privileges the head as is customary in western epistemology" (Bartlett, 2002a, p. 378). The resulting representations of breastfeeding often contradict or are only marginally related to women's particularized experiences breastfeeding. Regarding the corporeal body as "dumb and passive container" inhibits the possibilities of body- knowledges (Kirby, 1997, p. 148).

The breastfeeding vignette of the mother of the premature baby described above is one woman's reclamation of the possibility of her body-knowledges. Her body showed her how responsive it was to the persistent actions of her infant. Her embodied knowledge of her baby responding to his bodily knowledge spontaneously produced breastmilk from her opposite breast for the first time. She also became aware of an innate bodily knowledge that her tiny infant possessed. That is the ability to propel his body forward and gain access to food. Neither of these body-knowledges or embodied knowings came from the mind but rather were experienced in and through their bodies.

Previous vignettes and quotations in this chapter also give glimpses of embodied knowledge. The mother in the Stegner (1971) novel knew her baby's hunger in her blood as much as she knew this knowledge in her mind. The young mother who was holding one child in her arms and the other in her womb, knew and was close to these children because of an intimate knowing – a cellular knowledge transmitted through all

of their bodies. This was not a dichotomous knowing of the mind or the intellect, not "information" but an intimate, palpable knowledge of herself and her children. Giles (2003) in her description of breastfeeding her son said "We use the dialogue of the senses to grapples with each other's wishes" (p. 242).

Smith (1999a) said the "full meaning of a child, for us, resides in the paradox of being part of us but also apart from us" (p.139). This paradox is brought to life when we reflect upon a child. Erdrich (2005) captures some of these feelings and also the persistent presence of a child in the life of a breastfeeding woman.

> But the love an infant is of a different order. It is a twinned love, all absorbing, a blur of boundaries and messages. It is uncomfortably close to self-erasure, and in the fact of it one's fat ambitions, desperations, private icons and urges fall away into a dream life before that which haunts and forces itself in to the present with tough persistence" (p. 4)

Smith (1989) identified this "tough persistence" of children as "The Insistent Voice" (p. 223) or the presence and power of children in all of our lives. "The voice of children in the world is not merely ethereal, but it is also hard, fleshly, carnal" (p. 224). The breastfeeding child is clearly an exemplar of the corporeal presence of children. Further the mother and child embody each other in their corporeality.

Ross (1997) speaks of the emergence of truth through relationship and through bodies.

> Truth emerges here, belongs to and within, a relation to the other, the absolutely other, beyond any reach of the same of repetition or reassembling, beyond the reach of being. Yet it calls for, demands, elicits response, touches us with a gift that calls us to respond, exposes us to endless responsibility. Truth responds to the touch of the other. Truth emerges here in infinite *exposition/exposure*. This truth does not fade into the empty airiness of a singularity and uniqueness beyond the touch of embodiment (p.179-180).

The body has been largely devalued in traditional Western thought. Traditionally the body was seen to tie us to animals and it was only our capacity for reason that distinguished us. As a beastly quality the body was something to transcend. Yet, "Our understanding itself is embodied. That is, our bodily know-how, and the way we act and

move can encode components of our understanding of self and world" (Taylor, 1993, p. 309).

Breastfeeding can show us the wisdom that lies in the body and begin the repossession of women's bodies that Rich (1986) advocated. "I propose representing breastfeeding as an embodied, thoughtful and pleasurable practice in which breasts are powerfully active and women are empowered, knowing and desiring subjects (Bartlett, 2003, p. 20). The representations of breastfeeding shown in this chapter do exactly what Bartlett proposed. Further these breastfeeding representations show the embodied nature and bodily knowledge of infants.

Creative, ecological relational experience

The final breastfeeding contribution that I will discuss is breastfeeding as an exemplar of a creative, ecological and relational experience. Immersion in or reflection upon the breastfeeding experience can take us back to the mystery.

The story from the mother of the premature infant shows the mystery that inheres in the creative, ecological and relational experience of breastfeeding. This mother's relationship with her premature infant had been kept at a distance – always filtered and mediated through with various experts, institutional bureaucracies and technologies of the neonatal care unit - keeping the baby alive but also keeping the mother and infant apart. This story occurs months after the baby's birth. Finally home alone with her baby these intervening forces drop away and she and her child are able to be in-relation together. Magically the mystery and the beauty of life unfolded.

Why is a return to the mystery important? Many argue that our future depends on it (Berry, 2000; David Jardine, 2000; D. W. Jardine, 2000b; Kabat-Zinn, 2005). Our future is shaped by how we nourish and protect all that is good and beautiful and healthy in ourselves and the world. How we hold and understand this moment shapes what might emerge in the next moment, and the next. It shapes it in ways that are undetermined and ultimately undeterminable until the moment unfolds. Yet global warming scientists tell us we have probably passed a critical juncture for life on planet earth. How have we come to this point?

Taylor (1991b) two decades ago identified the primacy of instrumental reason as a threat to our existence. Smith (2000) stressed there are "two fundamental assumptions

still at play in the self-understanding of the West: a) that is it application of Reason that enables an understanding of the world because b) it is in the nature of world that it is reasonable" (p. xi). These two assumptions have worked to subvert our awareness of our interdependency with the natural world. Instead humans have considered themselves superior and able to manipulate and control the outcome. Our "reasonable" hubris will be our demise. Control and competiveness in our world has paralyzed us and stopped us from uniting to gather the goodness that is there. Control does not call or touch us with awe. Instead control can diminish, stagnate and destroy. Control implies struggle and resistance. Competitiveness (McMurtry, 1998) and individualism (Taylor, 1991b) have pitted us against another and diminished our communal commitments (Taylor, 1991b) and our concern.

Entering the mystery offers a very different picture of the world. Symmons (2002), in the quotation on the second page of this chapter, noted that participating in the mystery requires a letting go of solutions. This giving up of control and fixing is the first and most difficult lesson of falling.

"For we are in intimate relationship with the world in all our moments. The give-and-take of that relationality is continually shaping our lives. It shapes and defines the world in which we live and in which our experiences unfold." (Kabat-Zinn, 2005 p. 3) When we are continually insensitive to or deny the "symbiotic dance of reciprocity of interdependence on every level" (Kabat-Zinn, 2005 p. 3) there is a resultant profound break in the reciprocal rhythm of things. However, examination of breastfeeding can immerse us in the mystery and beauty of life. As noted in the first section of this chapter breastfeeding is based on a very responsive reciprocal rhythm and deep interconnection. Thus breastfeeding is a clear example of an unique of form of interdependence. "Interdependence, then, is found in that relational space between – where we live all our senses (embodiment), where we meet each other (improvisation) and we come to engage with nature as home (locating ourselves reciprocally)" (Bergum, 2003, p. 127). "

One alternative to the mystery is control. Jardine, elaborating Wendall Berry's differentiation of control versus mystery, said the following

> the notion of mystery entails that we are connected to and dependent upon what falls outside the sphere of knowing. On the basis of such a notion,

> we must act the basis of ignorance. Our actions must become delicate and careful and attentive to what crackles beyond the boundaries that our knowledge has set (Jardine, 1998b, p. 119)

Bergum (2003) identifies interdependence as an important theme in her discussion of pedagogical relation. For her interdependence locates teaching in a reciprocal world as home.

> Brendan Leier describing the Eastern concept of way or path:
>
> To follow the way is to integrate one's being with the nature of nature or the reality of the world. It is a communion of self and world, a revelation of one's own essence in relation to the greater environment. To be virtuous is to blend into and integrate with the world; to suffer is to struggle against the nature, to stand against the flow of the universe (Leier, 2007, p. 23).

He notes that there is not similar concept in Western thinking. Many have gone further to state that quite a different attitude runs through Western thought. The attitude of the West is that man actually can predict and therefore control nature. Using Leier's conceptualization we are resigning our selves to perpetual struggle when we try to control and stand "against the flow of the universe"

The nurses at the Breastfeeding Centre have created a portal that allows mothers and their infants to entered into breastfeeding as a mystery, not only as a problem to be solved. Further this portal allows the mothers and their babies to enter into the flow of the universe. It is a space where the humanity is honored, it is a place that reveres health and humanity. By acknowledging the health (wholeness of the world) it is a place that returns to foundational respect for other humans. Through recognition of the benefits of breastfeeding it points to possibility and fosters creativity. Breastfeeding can teach us about living, growing reciprocal relationships in constant renewal and transformation and ultimately about what it means to be human. A hermeneutic view of breastfeeding can challenge motherhood discourses about control.

Truth is a response to the wonder and the mystery and the good of life in all its wholeness. Truth is not something one can have or possess. Rather, the seeking and gathering of the good and the truth describes an great act of generativity. Unlike many conceptions of truth, including Ezzo's, the truth Ross (1997), describes not attempt to

make static, what is relational. We are called to look for and bring forth possibilities of new understandings and new ways of being. The gathering of this truth asks us to look repeatedly together for what is shown and known but also what is hidden and unknown. Truth asks us to bring forth what is presently understood and not yet understood in our interactions with others but also in our interactions with the Earth our home.

The idea of the good, as interpreted by Ross (1997) as nature's abundance, gives both truth and beauty as gifts. Thus the gathering of this truth requires responsiveness not only to the human condition but also to the wholeness of our earth. It requires us to be profoundly aware of and concerned with the other and our world. It asks out to use our collective intelligence to respond to the needs of children, of adults, of nature and the planet.

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Appendix A

Nurse Information Sheet

INFORMATION SHEET FOR NURSES AT THE KELOWNA BREASTFEEDING DROP IN CENTRE.

Title of Research Project: Truth in Nurse-Patient Relationships

Investigator: Diane Gamble, RN, PhD Candidate, Faculty of Nursing, University of Alberta; Okanagan University College, Associate Professor. Phone: (250) 762-5445, local 7967.
Email: dgamble@ouc.bc.ca
Supervisor: Dr. Brenda Cameron, Associate Professor, Faculty of Nursing, University of Alberta.

Purpose of the Study: The purpose of this study is to understand the meaning of truth for nurses and mothers at the Kelowna Breastfeeding Drop-in Centre. This study is part of doctoral studies in the Faculty of Nursing at the University of Alberta.

Background: The relation between nurses and mothers is important for good care. Knowing more about the meaning of truth for them will help promote better care.

Procedure: I would like to observe your interactions with the mothers at the Centre. During this time, I would like to audio tape your interaction with the mother and her child. This will assist me to remember what happened. I would also like to take notes during my observation. Observation times will take place as often as you wish until completion of the study to a maximum of four clinics. I may also invite you to participate in a conversation about your experience working with mothers. This will take place at a time and location that is good for you. The conversation will take about one hour to one and a half hours. With your consent, our conversation will be audio taped. If you agree to participate in the study, I will ask you to sign a consent form.

Benefits and Risks: There are no known health risks to taking part in this study. Some individuals may find the conversation useful.

Voluntary Participation: Your participation is voluntary. If you do not wish to participate, this will not affect your status at the Centre in any way. Your supervisor will not be informed. You may ask me not to use the tape recorder or take notes. You may refuse to answer any question. You may withdraw from the study at any point in time.

Confidentiality and Anonymity: All information will be held private, except when professional codes of ethics or the law requires reporting. We will keep tapes and written material from the study in a locked filing cabinet. Only my supervisor, my doctoral committee, and myself will have access to the data. A typist will have temporary access to the data. We will delete all identifiable from all the records. We will assign a number

to each tape, transcript, and to any other material that results from your participation in this study. We will keep the tapes for at least seven years after the study is completed. Consent forms will be stored separate from the tapes. We will keep consent forms for at least seven years.

Given that nurses working at Breastfeeding Drop-In Centre in Kelowna are a small group, we cannot guarantee full anonymity. Steps to safeguard anonymity will be taken. Research findings may not relate to one particular nurse but to a number of them. We will delete any particular characteristic that may identify you. As well, some of the data collected with participants may not be used for this study if it might identify you.

Future use of data: We may present findings from this study in conferences. We may also publish some of the findings. Your name will not appear in any report. Information collected in this study may be used in future studies. If so, we will request permission from a research ethics board.

Study Results: Upon completion of the study, you will receive a summary of the results. These will be sent to your workplace. The researcher will also present the results to the Kelowna Public Health Nurses.

Additional contacts: For additional information or information any time during the study, you can contact Diane Gamble at (250) 832-0927 or Dr Brenda Cameron (780) 492-6412. If you have any concerns, you can contact Dr Michelle Mantle, Chair Research Ethics Board, at Okanagan University College at (250) 762-5445 ext. 7850. You may also contact Dr Kathy Kovac Burns, Director Research Office, Faculty of Nursing, University of Alberta at (780) 492-6832.

If you agree to take part in this study, please contact Diane Gamble and she will take your informed consent.

Appendix B

Nurse Consent for Observation and/Or Conversation

CONSENT FORM FOR NURSES AT THE KELOWNA BREASTFEEDING DROP IN CENTRE.

Title of Research Project: Truth in Nurse-Patient Relationships

Investigator: Diane Gamble, RN, PhD Candidate, Faculty of Nursing, University of Alberta; Okanagan University College, Associate Professor. Phone: (250) 762-5445, local 7967 Email: dgamble@ouc.bc.ca

Supervisor: Dr. Brenda Cameron, Associate Professor, Faculty of Nursing, University of Alberta.

To be completed by the participant

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Do you understand your participation is voluntary?	Yes	No
Have you had an opportunity to ask questions and discuss the study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you give permission for the investigator to contact you to ask follow up questions?	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____	_____	_____
Signature of Research Participant	Date	Witness (optional)
_____		_____
Printed Name		Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Investigator or Designee	Date

I have received a signed copy of the consent form.

_____ Signature of the Participant

Appendix C

Mother Observation Information Sheet

INFORMATION SHEET FOR MOTHERS PARTICIPATING IN KELOWNA BREASTFEEDING DROP IN CENTRE OBSERVATION.

Title of Research Project: Truth in Nurse-Patient Relationships

Investigator: Diane Gamble, RN, PhD Candidate, Faculty of Nursing, University of Alberta; Okanagan University College, Associate Professor. Phone: (250) 762-5445, local 7967.
Email: dgamble@ouc.bc.ca

Supervisor: Dr. Brenda Cameron, Associate Professor, Faculty of Nursing, University of Alberta.

Purpose of the Study: The purpose of this study is to understand the ways nurses and mothers interact at the Kelowna Breastfeeding Drop-in Centre. This study is part of doctoral studies in the Faculty of Nursing at the University of Alberta.

Background: The relation between nurses and mothers is important for good care. Knowing more about their relation will help promote better care.

Procedure: I would like to observe your interactions with the nurse and your child at the Centre. During this time, I would like to audio tape your interaction with the nurse. This will assist me to remember what happened. I would also like to take notes during my observation. The number of observations times will not exceed three. If you agree to being observed, your nurse will ask you to sign a consent form. At a later time, I may also invite you to talk about your experience at the Centre.

Benefits and Risks: There are no known health risks to taking part in this study. Some individuals may find participation in the study useful. Some people may be uncomfortable participating.

Voluntary Participation: Your participation is voluntary. If you do not wish to participate, this will not affect your care or the care of your baby. You may ask me not to use the tape recorder or take notes. You may refuse to answer any question. You may withdraw from the study at any point in time.

Confidentiality and Anonymity: All information will be held private, except when professional codes of ethics or the law requires reporting. We will keep tapes and written material from the study in a locked filing cabinet. Only my supervisor, my doctoral committee, and myself will have access to the data. A typist will have temporary access

to the data. We will delete all identifiable information from all the records. We will assign a number to each tape, transcript, and to any other material that results from your participation in this study. We will keep the tapes for at least seven years after the study is completed. Consent forms will be stored separate from the tapes. We will keep consent forms for at least seven years.

Future use of data: We may present findings from this study in conferences. We may also publish some of the findings. Your name will not appear in any report. Information collected in this study may be used in future studies. If so, we will request permission from a research ethics board.

Study Results: Upon completion of the study you will receive a summary of the results. The summary will be mailed to you, or if you prefer not to leave your address, arrangements will be made for a convenient pickup location.

Additional contacts: For additional information, you can contact Diane Gamble at (250) 762-5445 local 7967, or Dr Brenda Cameron (780) 492-6412. If you have any concerns, you can contact Dr. Michele Mantle , Chair, Ethics Review Board, Okanagan University College at (250) 762-5445 ext. 7850. You may also contact Dr Kathy Kovac Burns, Director Research Office, Faculty of Nursing, University of Alberta at (780) 492-6832.

If you agree to take part in this study, please inform your nurse.

Appendix D

Mother Consent Form

CONSENT FORM FOR MOTHERS ATTENDING THE KELOWNA BREASTFEEDING DROP IN CENTRE.

Title of Research Project: Truth in Nurse-Patient Relationships

Investigator: Diane Gamble, RN, PhD Candidate, Faculty of Nursing, University of Alberta, OUC Associate Professor. Phone: (250) 762-5445, local 7967 or Email: dgamble@ouc.bc.ca

Supervisor: Dr. Brenda Cameron, Associate Professor, Faculty of Nursing, University of Alberta.

To be completed by the participant

Do you understand that you have been asked to be in a research study? Yes No

Have you read and received a copy of the attached Information Sheet? Yes No

Do you understand the benefits and risks involved in taking part in this research study? Yes No

Have you had an opportunity to ask questions and discuss the study? Yes No

Do you understand your participation is voluntary? Yes No

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason. It will not affect your care. Yes No

Has the issue of confidentiality been explained to you? Yes No

Do you give permission for the investigator to contact you to ask follow up questions? Yes No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____

Signature of Research Participant Date Witness (optional)

_____ _____

Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____

Signature of Investigator or Designee Date

I have received a signed copy of the consent form.

_____ Signature of Participant

Appendix E

Mother Personal Conversation Information Sheet

INFORMATION SHEET FOR MOTHERS PARTICIPATING IN PERSONAL CONVERSATION

Title of Research Project: Truth in Nurse-Patient Relationships

Investigator: Diane Gamble, RN, PhD Candidate, Faculty of Nursing, University of Alberta: Okanagan University College, Associate Professor. Phone: (250) 762-5445, local 7967. Email: dgamble@ouc.bc.ca

Supervisor: Dr. Brenda Cameron, Associate Professor, Faculty of Nursing, University of Alberta.

Purpose of the Study: The purpose of this study is to understand the ways nurses and mothers interact at the Kelowna Breastfeeding Drop-in Centre. This study is part of doctoral studies in the Faculty of Nursing at the University of Alberta.

Background: The relation between nurses and mothers is important for good care. Knowing more about their relation will help promote better care.

Procedure: If you agree to participate in a conversation to talk about your experience at the Centre, you can contact me at the number below. The conversation with take place at a time and location that is good for you. With your consent, our conversation will be audio taped. I will ask you to provide some general information about yourself (for example, your age, number of children). The conversation will take about an hour or a little more.

Benefits and Risks: There are no known health risks to taking part in this study. Some individuals may find participation in the study useful. Some people may be uncomfortable participating.

Voluntary Participation: Your participation is voluntary. If you do not wish to participate, this will not affect your care or the care of your baby. You may ask me not to use the tape recorder or take notes. You may refuse to answer any question. You may withdraw from the study at any point in time.

Confidentiality and Anonymity: All information will be held private, except when professional codes of ethics or the law requires reporting. We will keep tapes and written material from the study in a locked filing cabinet. Only my supervisor, my doctoral committee, and myself will have access to the data. A typist will have temporary access to the data. We will delete all indentifiable information from all the records. We will assign a number to each tape, transcript, and to any other material that results from your participation in this study. We will keep the tapes for at least seven years after the study

is completed. Consent forms will be stored separate from the tapes. We will keep consent forms for at least seven years.
Future use of data: We may present findings from this study in conferences. We may also publish some of the findings. Your name will not appear in any report. Information collected in this study may be used in future studies. If so, we will request permission from a research ethics board.

Study Results: Upon completion of the study you will receive a summary of the results. The summary will be mailed to you, or if you prefer not to leave your address, arrangements will be made for a convenient pickup location.

Additional contacts: For additional information, you can contact Diane Gamble at (250) 832-0927 or Dr Brenda Cameron (780) 492-6412. If you have any concerns, you can contact Dr Michele Mantle, Chair, Research Ethics Board, Okanagan University College at (250) 762-5445, local 7850. You may also contact Dr Kathy Kovac Burns, Director Research Office, Faculty of Nursing, University of Alberta at (780) 492-6832.

If you agree to take part in this study, please call Diane Gamble at (250) 762-5445 local 7967.

Initials: Mother: Researcher: